STATE TITLE V BLOCK GRANT NARRATIVE
STATE: AK
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The Commissioner of the Department of Health and Social Services signs the Title V application with the required Assurances and Certifications attached for reference. This information is also kept on file in the Division of Public Health, 4501 Business Park Blvd., Anchorage, Alaska 99503.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

A public notice informing the general public that Alaska's Title V MCH Block Grant application is available for review was posted on the state's on-line public health notice system on July 5, 2005. In addition, all of the members of the focus groups used during the needs assessment process were notified as part of their update regarding the needs assessment and the state's performance measures chosen as part of their work. Finally, several key stakeholders and partners were individually contacted and provided the opportunity to review the application. These agencies included: The March of Dimes-Alaska Chapter; Public Health Nursing director office, Alaska DHSS Primary Care and Rural Health Unit, the All Alaska Pediatric Partnership, Department of Education and Early Intervention, the Governor's Council on Disabilities and Special Education, the Office of Children's Services Early Intervention and Infant Learning program as well as the WIC program and Health Families program. To date five requests have come into the office for copies of the grants. No comments were recieved prior to July 15, 2006.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

As of July 1, 2005, the Division of Health Care Services transferred the former MCH programs back to Public Health. Until now, this division administered the State of Alaska's Title V funds, provided health services and support to families, child-bearing women, and children with special health care needs (CSHCN). This is discussed in more detail below in the 2006 update.
/2002/ Alaska's health care system differs from most other states in that there are virtually no local health departments that function under the umbrella agency of the state health department. Two communities have locally organized health departments -- Anchorage and the North Slope Borough. In addition to these two local health departments, the entities operating in Alaska to deliver health care services include: the Department of Health and Social Services; private physicians and other health care providers; private hospitals; federally funded hospitals (military and Native); non-profit federally funded community health centers; and Native health corporations. Coordination of service delivery and systems development is an ongoing effort within the state among these entities.
//2003// No change.
/2004/ The Health Care Delivery Environment:
In December of 2002, a new Governor was sworn in to begin a four-year term of office. A change of administrations, especially when it involves a change in political parties as this one has, always brings changes -- new commissioners and top-level managers, new ideas and new philosophies. Alaska has experienced all of these including the appointment of a new Commissioner of Health and Social Services (DHSS). Senior management changes have also been made with the appointment of new Deputy Commissioners and Directors for most of the principal divisions within the DHSS. In addition to these administrative changes, on March 4, 2003, the Health and Social Services Commissioner announced a major reorganization of the DHSS. The reorganization includes internal consolidations that result in name and function changes for four divisions and the transfer of partner programs into the DHSS from other state departments. In part, the reorganization will restructure the way Alaska uses Medicaid funding for programs and maximize federal funding for state services.

The reorganization will result in significant changes for MCH programs. As of July 1, the Section of Maternal, Child and Family Health (MCFH), the agency that administers Title V funds, will be dissolved and specific programs and services within MCFH reassigned to new or existing Divisions within DHSS. Following is a list of the Divisions within DHSS that will have program responsibility for MCH programs formerly consolidated in the Section of MCFH.

Office of Children's Services (formerly Division of Family and Youth Services). In addition to child protective functions, the Office will include the following MCFH programs: Adolescent Health; Children's Initiatives/Special Projects; Healthy Families Alaska; Infant Learning/Early Intervention Program; WIC/Nutrition Programs; Community and Family Nutrition.

Division of Health Care Services (a blending of some MCH programs and the Division of Medical Assistance - DMA). In addition to Medicaid-related functions from DMA, the Division will include the following MCFH programs: Breast and Cervical Cancer Screening; Oral Health; EPSDT; Family Planning; Genetic Screening; Newborn Metabolic Screening; Newborn Hearing Screening; Specialty Clinics; Women's Comprehensive Health Care Initiative. The MCH Title V Block Grant will be administered by this division.

Division of Public Assistance. In addition to the current functions, the following programs will be transferred into the Division: Denali KidCare Outreach from MCFH; Child Care Block Grant Lead Agency from the Department of Education. The current Denali KidCare outreach positions located in MCFH are eliminated from the budget, effective July 1, 2003.

Division of Behavioral Health (formerly Division of Mental Health and Developmental Disabilities). In addition to mental health programs from the former division, the following function currently under MCFH will be incorporated: Children's Behavioral Health. The Children's Behavioral Health Coordinator position currently located in MCFH is eliminated from the budget, effective July 1, 2003.

Division of Public Health. The MCH EPI Unit will move to the Section of Epidemiology and the Family Violence and Prevention Project will move to the Section of Community Health and Emergency Medical Services/Injury Prevention.

As part of the functional reorganization of DHSS, program staffing and budget adjustments and reductions are anticipated and will alter the way in which services are delivered or programs are supported. The reorganization is expected to present challenges as well as opportunities to address significant health issues faced by MCH populations in the state. Effects of the reorganization will be discussed in each of the sections of this grant application.

Principal characteristics important to understanding health needs of the state's population:
While Alaska is actively changing the way it administers programs and services for the MCH populations, significant health issues continue to demand our attention and thoughtful planning and delivery of health services.

Alaska is a large, sparsely populated state. According to 2000 Census data, the population of the state is 626,932. The land mass of the state encompasses 571,951 square miles, averaging a population density of just 1.1 persons per square mile; the lowest population density of any state. Approximately half (373,834) of the state's total population lives in three urban boroughs: the Anchorage Municipality, the Fairbanks North Star Borough and the Juneau City and Borough. The remaining population lives in frontier/remote areas of the state. (Defined as 0.5 to 9.9 persons per square mile for frontier areas and 0.4 persons or less per square mile for remote area designations.) Approximately 75% of Alaskan communities, where over half of the population lives -- including the state's capital city of Juneau -- are not connected by road systems and rely on air or boat travel to connect them to urban areas. Accessing "nearby health services" or specialized health care for these populations means travel by air or marine transportation systems. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Specialty care, even in urban areas of the state, is limited. For example, the only neonatal intensive care facility is located in Anchorage. Alaska faces significant challenges in assuring all MCH populations have access to acute medical and specialty care. For populations living in non-urban areas, a challenge also exits to provide routine preventive care such as well-child check-ups, prenatal exams and regular dental exams.

Other defining characteristics of the state's population are the racial groups and geographic distribution of those groups. The results from the 2000 Census data indicate that the majority of the population of Alaska is white only (69.3%). A significant proportion is Alaska Native/American Indian only or Alaska Native/American Indian in combination with another race (19%). Approximately 5% of the population is Asian and 4% African American. Hispanic/Latino ethnicity was reported by 4.1% of the population. Geographically, the racial distribution differs from the total population in many areas of the state, with whites the minority in a number of areas. For example, Alaska Natives/American Indians make up more than 75% of the population in 8 of 14 remote areas of the state. Forty-six percent of Alaska Natives live in communities of less than 1,000 people. The largest minority population, Alaska Native, is much younger on average than the state as a whole (25.8 years). The largest differences in health status in the state are between Alaska Natives and the white population. Efforts of public and tribal health agencies have improved the health status of Alaska Natives over the years in many areas such as injuries and infectious disease, but some disparities persist. Health indicators show that Alaska Natives are at higher risk for a number of health issues. For example, key indicators show that Alaska Natives have higher rates of infant death and deaths among children (age 1 -- 19 years), lower rates of prenatal care, higher rates of smoking during pregnancy, teen births and suicide mortality. These health risks combined with the fact that the majority of Alaska Natives live in frontier/remote areas where access to health care is limited, place Alaska Natives at even higher risk for poor health outcomes.

Alaska is a fairly young state, where the median age is 32.4 years. This compares to 35.3 years for the entire United States. Residents age 65 or older comprise only 5.7% of the population of Alaska

compared to 12.4% for the U.S. population. Because the population is younger, fertility and birth rates are higher. Additionally, families living in non-urban areas tend to have larger families. The average family size (from 2000 Census data) in urban boroughs was 3.16 people. In frontier/remote areas combined it was 3.51 people. Alaska has the second highest fertility rate among the 50 states. The total fertility rate for Alaska (71.4 per 1,000) remains considerably higher than the national average (65.4 per 1,000). A significant decline in the overall teen birth rate has occurred (30 percent decline between 1990 and 1999 primarily attributed to the decline in births to females age 18 -- 19); however data indicate that Alaska Natives have over twice the rate of teen birth as whites.

Finally, characteristics that requires a significant investment of resources are the behavioral health issues that impact MCH populations in the state. Alaska has the unfortunate distinction of having the highest suicide rates in the county. The suicide mortality rate is 100 percent higher in Alaska than the national rate. Mental health disorders, stressful life events and substance abuse are risk factors for suicide. Alaska also has the distinction of the highest alcohol consumption rate in the nation. Alaskans have higher percentages of binge and chronic drinkers than the nation as a whole. Children are significantly impacted by alcohol and drug abuse, especially if their mothers are abusing. A majority of families in Alaska in the child protection system have problems with alcohol or drugs. The state has recognized and responded to significant behavioral health issues facing older populations and adolescents. Recently the state has also recognized that younger populations including infants and toddlers are a population that can and does have behavioral health needs.

Current State Priorities and the MCH health role and responsibility

The Department of Health and Social Services has developed the following goals and strategies for FY04-FY06:
Goal #1: Establish fiscal stability to DHSS programs through federal fund maximization, prudent cost containment, and streamlined business processes. Reduce dependence on new state general funds through the following: replace $20 million in state dollars with federal Medicaid dollars in FY04 by implementing agreements between hospitals and state-funded community programs; offset $5 million in state dollars in FY04 with federal Medicaid dollars by investment in Alaska Native tribal health services infrastructure through cooperative agreements with the state, private health care providers, local communities and tribal programs; review business process and eliminate inefficiencies and redundancies; conduct program reviews of all DHSS programs to find options for offsetting state funds with federal funds; carry out aggressive federal agenda to lock in fair treatment of Alaska in funding formulas and policies across a diversity of federal programs; implement cost containment options to the extent feasible without disruption to essential services.

Goal #2: Expand access to cost effective quality services in underserved areas of Alaska through the following: carry out aggressive health and social services workforce development agenda in collaboration with the University, tribal health system, provider and employer organizations, and other stakeholder groups; develop integrated health services programs utilizing partnerships with the tribal health systems, the Denali Commission, the Alaska Mental Health Trust Authority, and other stakeholder groups; implement reimbursement for telehealth services; support the increased use of well-trained local residents in the delivery of a range of frontline prevention and treatment services under tribal health program auspice, for maximum federal fund benefit through Medicaid; develop juvenile substance abuse treatment capacity in rural Alaska.

Goal #3: Protect children and the public from negative effects of alcohol and substance abuse; reduce impact of illness and injury and promote self sufficiency for all Alaskans through the following: establish Performance Improvement Plan (PIP) for child protection system (DFYS); maximize available resources to assure completion of the API replacement project; to assure juvenile offenders are held accountable; to open Kenai Youth Facility promptly; to renovate Nome Youth Facility; and to achieve expedited compliance with court directed treatment and tobacco enforcement policy; develop in-state capacity for provision of appropriate behavioral health services to children and youth, utilizing financing arrangement that assures best use of federal funds whenever feasible; maximize federal resources to support environmental health, disease control, injury prevention, and Homeland Security

programs in Alaska; strengthen home and community based services programs and self-sufficiency programs to achieve improvements in quality and cost effectiveness.

All programs and services will be reviewed in context of the new Department goals. Based on these goals, the new Department organization, and the upcoming five-year needs assessment, the state's MCH priorities may change.
Current MCH programs have supported/will support the DHSS priorities as follows:
Participated in a critical review of programs to identify efficiencies and funding options;
Complete the "Rural to Remoteness: An Overview of Maternal, Child and Family Health in Region X States" initiative in collaboration with Idaho, Oregon and Washington, and continue to work with the MCFH Bureau to use this information to critically assess funding formulas for rural/remote/frontier areas in the states and to develop initiatives between state and federal government to reduce health disparities between urban and non-urban areas;
Continue collaboration with Native organizations to plan for and provide MCH services to Native populations;
Support local expertise in the provision of MCH services through the development of paraprofessionals to deliver WIC and Infant Learning Program services;
Supported state capacity to provide behavioral health services for children through the MCFH infant/toddler behavioral health grant;
Support community-based services through the continuation of grants to local organizations for MCFH services.

The Process to Determine Alaska's MCH Priorities:
A statewide needs assessment is completed every five years to guide the planning and delivery of health care services, and to establish MCH priorities for the state. The needs assessment is comprehensive, gathering information and data from MCH programs, partner programs and communities through a series of community based forums. During the interim years of the needs assessment cycle, an MCFH management team reviews the needs assessment to see if it is still valid, update relevant data, identify emerging issues from MCH populations and other factors which may affect the state's ability to address MCH health needs such as legislative mandates, state and national funding or personnel/ management changes. The management team, in consultation with programs and community partners may determine that a shift in focus or priorities is warranted. For example, MCFH has received increasing reports of concern from parents, child care providers, teachers and health care providers related to the behavioral health of young children. This trend is supported by national data demonstrating that 1 in 10 children have a mental health disorder that causes significant impairment in function. According to U.S. Census data gathered in 2000, Alaska has 47,591 children less than five years of age. The current system of services in the state for children between the ages of birth to five with potential mental health disorders is inadequate to address the needs of this population. In response, the MCFH identified children's behavioral health as an emerging issue and responded by establishing an Early Childhood Behavioral Health Coordinator position, sponsoring three annual training institutes in infant/toddler behavioral health. MCFH also applied for and received a federal U. S. Department of Health and Human Services 17 month planning grant. Proposed grant activities included conducting a needs assessment to understand the nature and extent of the capacity and barriers in Alaska's mental health system for young children, developing an action plan based on the findings of the needs assessment and raising public awareness of the importance of positive mental health in the early childhood years.

Disparities
Three years ago, MCFH facilitated a process for Region X states (Oregon, Washington, Idaho and Alaska) to look critically at health disparities between urban and non-urban populations. Using existing population and MCH health data, information about health care delivery systems and geographical characteristics; states were able to build a detailed picture of their MCH populations, their health status and barriers to accessing health services.

This research effort documents that significant disparities do exist in Alaska between urban and non-urban populations. Information on selected MCH health status indicators for Alaska show important

differences in the prevalence, mortality, burden of disease and other adverse health conditions between urban and non-urban populations. For example, the average rates for those living in frontier and remote areas of Alaska were significantly higher in the majority of the indicators including childhood mortality, teen pregnancy, fertility, mothers reporting smoking and drinking. The rates also indicate that fewer women received early and adequate prenatal care.

Despite their poor health status, frontier and remote area MCH populations are less likely to access needed health care services. There are fewer health care facilities in non-urban areas. A low population means a smaller patient base to support health care facilities such as a hospital or clinic. In some remote Alaska communities, services are provided through a village health clinic staffed by a Community Health Aide. The lack of medical infrastructure in a small community and a limited patient base means that specialty services are rarely available or often nonexistent in frontier and remote areas. Recruiting and retaining physicians and primary health care providers for non-urban practices is also a barrier to providing health care services. Even if ideal health care systems were in place, socio/economic factors create additional barriers for populations living in frontier and remote areas. Compared to urban populations, frontier and remote populations are poorer, lack health insurance, have limited employment opportunities and face cultural or language barriers. Poverty is correlated with many of the health status and access disparities for non-urban populations. Higher unemployment, lower wage jobs and seasonal industries all contribute to the high poverty and near-poverty levels for non-urban populations. Uninsured populations are less likely to access routine, preventive care and more likely to seek care when health problems are severe and require treatment. Lack of preventive health care is a major contributor to poor health status for MCH populations.

The majority of residents in Alaska's frontier and remote areas are Alaska Natives. As previously noted, Alaska Natives are at higher risk for health problems compared to the general population. A culturally diverse workforce that reflects the culture, language and respects the traditions of the populations is a crucial strategy for reducing health disparities. While the state has made progress creating an infrastructure to train and recruit a culturally diverse workforce, many Alaska Natives do face cultural barriers when accessing health care. MCH supports local expertise and culturally competent care in the provision of MCH services through the training and development of paraprofessionals to deliver WIC and Infant Learning Program services.

Faced with the lack of appropriate health care in frontier, remote and even some urban areas of the state, residents are forced to travel to other communities for health care. Travel to access health care creates additional burdens for both the MCH populations, for the health care systems and the financial systems that support health care services. Families are forced to leave their homes and family support systems. For families with CSHCN, this can be particularly stressful. Families with children who require specialty care face hard choices when the services they need are not available in their community. They may have to choose between remaining in their community and traveling as often as needed for health care services; moving to an urban area where services are readily available and leaving their family and community support systems; remaining in their community and accessing itinerant care when it is available, or possibly getting no services at all. //2004//
/2005/No change in the goals or priorities of the department. //2005//
/2006/ Although the goals and priorities have not changed with this administration, a change in the Director of Public Health has helped to consolidate the focus of public health and look for opportunities to utilize the principles of quality improvement in shaping the role of public health. Prior to the start of fiscal year FY05, a new public health director was hired. The new Director, Dr. Richard Mandsager, was well known in public health circles as a local pediatrician with Southcentral Foundation--a health arm of Cook Inlet Tribal Association--and former administrator of the Alaska Native Medical Center. In addition, he had been an active participant in a variety of MCH projects and committees prior to the change in administration. One of his goals joining the administration was to work toward reformulating an MCH section and evaluate what made the most sense in terms of transferring programs back to public health. With the assistance of the former mangers in the MCH programs and the former section chief, a proposal was presented to the Commissioner for his consideration in September of 2004. The proposal was approved in October of 2004. A new section chief (Title V/CSHCN

Director) was appointed and the former MCH programs that resided in the Division of Health Care services as well as the MCH Epidemiology program (then in the Section of Epidemiology, Division of Public Health, began to programmatically report to the new section chief who reported to Dr. Mandsager. The new section name is the Section of Women's, Children's, and Family Health.

Since October of 2004, the Section Chief of Women's, Children's and Family Health (WCFH) and Title V/CSHCN Director has had a dual reporting relationship between the two divisions; that of Health Care Services and Public Health. This has enabled her to continue to offer public health policy considerations and information regarding potential outcomes when Medicaid policy was being considered. In addition, she has continued to work on regulation changes for current and new Medicaid programs including home health (regulations affected payment methodology and streamlined processes for pregnant women and children to be considered eligible for home health care services); school based services including PT, OT, speech and language and audiology services for Medicaid eligible children; Durable Medical Equipment regulations including audiology equipment of deaf and hard of hearing children and newborn/infants with Cleft Lip/Palate disorders; and travel policies affecting CSHCN. As she is the only master's prepared nurse (with experience in perinatal, neonatal and pediatric nursing) in Medicaid, her expertise regarding clinical issues is requested on a regular basis. Finally, she is leading a special quality improvement project in collaboration with her colleagues in Medicaid and the Medicaid waiver program to improve the discharge planning and placement process for medically fragile children discharged from the state's only Level III and tribal Level II NICUs, both of which are located in Anchorage. In summary, the work conducted in collaboration with Medicaid has provided a new pathway to working toward resolving health access issues, racial disparities, and improved an understanding of tribal health delivery and its relationship to the federal Medicaid system of payment.

Specifically the programs that are moving back to public health from health care services include those in the Children's Health Unit- Newborn Metabolic Screening, Newborn Hearing Screening (EHDI), Specialty Clinics, Birth Defects and Genetics Clinics, Oral Health for Children and Adults; and those from the Women's Health Unit-Family Planning, and the Breast and Cervical Cancer program. In addition, the Abstinence Grant administration will transfer from the Office of Children's Services.

In January of 2005, Dr. Mandsager presented a proposal in collaboration with the Deputy Commissioner of the Office of Children's Services (OCS), to move the former MCH programs that reside in OCS back to Public Health as well. The Commissioner denied the request at the time due to the upcoming election. As an interim measure, the Division Director of Public Health, and the Section Chief of WCFH have identified projects to collaborate on with the Manager and staff in OCS over this next fiscal year. The plan is to request consideration for transfer again in the fall of 2005 as the new budget year begins to be planned for FY07. The programs that will remain in the Office of Children's Services include WIC, Early Intervention/Infant Learning program, Healthy Families Intensive Home Visitation program, Community Nutrition and the 5-A-Day program and the Early Comprehensive Care Systems grant.//2006//

Increased Federal Support

Alaska has enjoyed increased federal support for a number of health and social service programs in the last year. A telemedicine program to link rural villages to health care facilities in large Alaska cities, immunization programs, and an initiative for childhood injury reduction are but a few of the areas that have received new or additional federal funding in the last fiscal year. The infusion of dollars for health and social services has meant that needed health programs have been able to be established and where programs were already in place, expanded to meet burgeoning demand.

/2002/ In FY01, Alaska received additional federal funding for several MCFH programs including: $1.86 million for expanded home visitation services, $30.0 from a special federal appropriation for FAS Surveillance, $247.0 for Title X, family planning expansion, and $420.0 in TANF funds for

pregnancy prevention.
/2003/ In FY02, Alaska received additional federal funding for the following programs: $190.0 for Population-Based Birth Defects Surveillance from CDC; $2.5 million (Better Beginnings II) in support of home visitation services (Healthy Families Alaska), $135.0 from CDC for Early Hearing Tracking, Research and Integration and $108.0 from MCHB for Women's Comprehensive Care Coordination.
/2004/ During FY2002, the Section applied for and received an oral health grant for $175,868 through CDC; a $50,000 planning grant from the Office of the Assistant Secretary for Planning and Evaluation for children's behavioral health; a $75,000 Using Loving Support grant from USDA for building a friendly breastfeeding community; and a $494,000 federal earmark administered through CDC for anemia research and treatment in the Yukon-Kuskokwim and Bristol Bay regions of the state. //2004//
/2005/ In FY03, the section of MCFH applied for and received a supplemental oral health grant in the amount of $39,000 to conduct a baseline open mouth screening survey of 3rd graders as part of data collection and assessment required to complete the oral health state plan;a $1.2 million (Better Beginnings III) earmark from Administration of Children, Youth and Families in support of intensive home visitation services (Healthy Families Alaska); a March of Dimes Leadership Grant in the amount of $15,000 for developing a folic acid community campaign that would be self sustaining as the March of Dimes moved into its next national campaign of "Prematurity Prevention"; and a total of $65,000 was received by the WIC program from USDA for training WIC center paraprofessionals in the breastfeeding "Using Loving Support" program. In addition, the study of anemia and the proposed treatment of H.Pylori as a treatment for anemia received an additional grant from HRSA as a federal earmark in the amount of $385,000 beginning August 1, 2003 as well as a non-cost extention of their previous grant award. //2005//
/2006/ In FY04, a $30,000 supplemental Oral Health award was received in support of the baseline open mouth screening survey. Another $1.3 million (Better Beginnings IV) earmark from the Administration of Children, Youth and Families in support of Healthy Families Alaska, an intensive Home visitation service was received. In collaboration with Alaska Health Fairs Inc. to apply for a March of Dimes community grant in support of reprinting the Alaska specific Folic Acid brochures and pay for the cost of mailing them throughout Alaska //2006//.

Alaska State Legislature
The Republican party has held the majority of seats in the Alaska State Legislature since the early 1990's. While numerous Republican candidates are up for re-election in November 2000, the balance of power is not expected to significantly change. While Alaska has had a Democratic Governor since 1994, the presence of a conservative Republican majority has had a financial impact on the entire Department of Health and Social Services in recent years. Of note is the FY98 move to eliminate the General Relief Medical Program which provided coverage for very low income persons with one of the following five conditions: Hypertension, Seizure Disorder, Diabetes Mellitus, Cancer requiring chemotherapy and Schizophrenia. Specific to MCFH has been the FY99 reduction in funding for the Healthy Families Alaska Program. Because increased federal support has allowed needed services and programs to be provided at little or no cost to the state, it is of concern to MCFH that the conservative majority will formulate an unrealistic view as to the actual cost of providing services and hold steady, or even reduce their portion of funding for services in the coming years.
On a more positive note is the possible introduction of "prescriptive equity" legislation in the next fiscal year. Scheduled to be introduced when the State Legislature convenes in January 2001, the measure would mandate insurance coverage for birth control for women in Alaska. Passage of such a law could increase access to birth control by reducing the financial barriers that many women face when managing their fertility. If introduced, MCFH will monitor with interest the movement of this legislation because of its positive impact on the health of women in Alaska.
/2002/ "Prescriptive equity" legislation was introduced in the 2001 legislative session but never got a hearing. In addition, there was a great deal of activity surrounding two bills, one related to a Newborn Hearing Screening bill and one related to Breast and Cervical Cancer treatment. The Newborn Hearing Screening bill would have mandated newborn hearing screening for all infants in the state. The bill did not make it through the session because of issues related to costs of covering screening for uninsured infants. After much debate and controversy, the Breast and Cervical Cancer Treatment bill finally passed, but with a sunset date in 2003. This bill provides Medicaid coverage for breast and cervical cancer treatment for women diagnosed through the federally funded Breast and Cervical

Cancer Early Detection Program in Alaska which is operated by MCFH.
/2003/ During the FY02 legislative session, HB173, which mandated UNHS in 90% of Alaska's births by 2003, was re-introduced, but failed to pass due to the fiscal note attached to the implementation of this legislation. A bill intended to reduce the number of people eligible for the state's SCHIP program was introduced by the legislature but died due to public outcry. An abortion reporting bill passed, a prescriptive equity bill died, as did a bill to eliminate the sunset date of the Breast and Cervical Cancer Treatment bill and a bill to change parent consent from active to passive for school-based surveys. A bill to restrict Medicaid payment for abortions passed but was vetoed by the Governor.
/2004/ The sunset clause of the breast and cervical cancer treatment bill was eliminated, ensuring Medicaid coverage for breast and cervical cancer identified among women screened through the state's screening program, Breast and Cervical Health Check. //2004//
/2005/ Legislation mandating Newborn Hearing Screening did not move out of the Finance committee despite bipartisan support. The fiscal note was again revised to reflect the anticipated ongoing expenses of infants and children diagnosed as hard of hearing or deaf that would be served in early intervention for a longer time period as a result of earlier identification. During the State FY04 legislative session a number of bills were passed impacting the public's health. Although not yet signed by the Governor, they include the following outlined in four areas. In the area of Access to Health Care: HB 10 amends the definition of group health insurance, and allows the Department of Administration to obtain a policy or policies of group health care insurance for employers that are small businesses, nonprofit organizations, special services organizations, or small associations for insurance purposes; HB 260 extends the ability of licensed physicians and other health care providers to administer health care services free of charge; SB 285 expands medical assistance coverage for targeted case management services. It also clarifies that school districts can seek reimbursement as Medicaid providers for services provided to students for rehabilitative services. In the area of Alcohol and other Drugs: HB 356 provides communities with the option to monitor the inflow of alcohol into their community through a locally operated distribution center. This bill extends the sunset date of alcoholic beverage site from July of 2004 to July 2008. This is particularly important in rural communities where the rate of alcoholism among teens and pregnant women is significant. Under House Bill 428 Civil Penalty: Underage Alcohol Purchases, an adult who orders or receives an alcoholic beverage, for the purpose of selling, giving, or serving it to a person under the age of 21 years, can be civilly liable to the licensee for a penalty of $1,000. Likewise, the parent or legal guardian of a minor that solicits an adult to violate AS 04.16.060, can be civilly liable for a penalty of $1,000 to the licensee from which the alcoholic beverage was purchased, ordered, or received; SB 224 is a bill relating to lowering the legal level of intoxication for operating a motor vehicle, aircraft, or watercraft to .02 percent or the equivalent for persons under 21 years of age; relating to implied consent for purposes of determining consumption of alcohol; and providing for an effective date. In the area of Injury Prevention: House Bill 213 creates a three-tiered system whereby young drivers pursue their full, unrestricted driver's license with clarification of the definition of who may receive an exception for provisional license. This will hopefully assist in decreasing the number of teen motor vehicle fatalities; HB 351 adds carbon monoxide detection devices to the requirement in Alaska state statute (AS 18.70.095) that homeowners install and maintain smoke detectors and adds that landlords shall install the devices to be maintained by their tenants; HB 381 addresses loopholes in Alaska Statute regarding vehicular related child endangerment. This bill includes specific provisions to our existing child endangerment statutes pertaining to transporting a child in a motor vehicle while intoxicated or transporting a child in a motor vehicle and failing to use proper restraints; and HB 398 authorizes the State of Alaska and its municipalities to empanel teams to systematically review facts of escalating cases of domestic violence fatalities. This legislation would provide state and local governments with additional tools to gather information on many aspects of Domestic Violence with clarification on how the annual report is handled. In the area of Reproductive Health; SB 30 is an Act relating to information and services available to pregnant women and other persons; and ensuring informed consent before an abortion may be performed, except in cases of medical emergency. SB 30 directs the Department of Health and Social Services to produce a website with information and resources for women seeking adoption, abortion, childbirth, and contraceptive services. The information will be organized according to geographic region. SB 30 requires a physician or other health care provider performing an abortion to obtain voluntary and informed consent as defined in the bill. The bill has been a source of significant controversy.//2005//

/2006/ The FY05 legislative session was the first year of a two-year rotation, so all bills introduced were considered new bills. In the area of Access to Health Care: HB 109 "Newborn Hearing Screening" was introduced by a freshman majority legislator from Fairbanks. This bill that includes requirements for screening, diagnostics, follow up for at-risk infants and surveillance, was again modified significantly by state staff to reflect the recent changes in the program. Additionally, a markedly lower fiscal note was submitted from the Division of Public Health, WCFH. For the first time in five years the bill moved out of the House with over 20 co-sponsors. However, it met with considerable resistance on the Senate side due to issues around mandated health programs and the requiring of insurance companies to pay for the screening and any required diagnostics. The sponsoring legislator and the advocates opted to wait out the session, develop a strategy, and approach some of the less supportive Senators over the summer months in preparation for the next session. It is scheduled for hearings in only two committees prior to a floor vote. SB 22 "Medicaid coverage for Birthing Centers", moved surprisingly quickly through the House and Senate with virtually no opposition, despite testimony by health care providers arguing against supporting birthing centers owned and operated by direct entry midwives--a paraprofessional level of midwifery based on the Appalachian midwives. The Title V Director shared data that demonstrated a high rate of morbidity and mortality with newborns born in the birthing centers with the Director of Public Health, as well as case examples of inappropriate care of pregnant women. The administration chose to remain neutral on the subject and the bill passed and is awaiting the Governor's signature. It is unclear if he will sign the bill or not. The changes that did occur in committee will implement licensing standards for freestanding birthing centers, but will not allow payment by state Medicaid funds until CMS recognizes birthing centers as a facility type for reimbursement. HB 85 "Prescribed Medications for Students" was a bill that will allow students who have asthma to carry their rescue inhalers with them on their person with the written approval of their physician. This bill is important as only a fraction of the schools in the state have school nurses. Frequently the school secretary, a teacher or the administrator will lock the inhalers in their office desk, leaving no access at the time a student might need it. In the area of Public Health Law and Infrastructure Bills, HB 95 "Public Health Disaster and Emergencies" bill provided for a complete overall of the public health powers of the state in preparation for emergencies situations. This was the first time the bill had been introduced and though it had many amendments, it survived relatively intact and experienced very little opposition. Other bills of interest for the MCH population that remain in committee include water fluoridation, a mandatory seat belt law, post-secondary immunizations of students for meningitis, school nutrition grants, and methamphetamine sales limitations//2006//

State Hiring/Travel Freeze
/2002/ There is no longer a hiring freeze and we are able to hire for vacant positions. There continues to be a cap on out of state travel.
/2003/ No change.
/2004/ No change.
/2005/ Position refills were closely scrutinized with additional justification required. Several positions were approved for replacement. Travel was capped allowing for only one staff member to travel to a given conference or meeting even when a grant required more. //2005//
/2006/ Positions were filled without significant barriers, providing funding was budgeted and available. With state salaries now lower than the private sector, especially in the professional areas, the number of applicants with experience has markedly decreased over the last couple of years. Thus, positions are sometimes vacant for almost a year or more before an adequately qualified candidate is hired. Travel authorizations were done at the Director level with an approved travel plan. Limitations on the number of staff attending out of state conferences or grant-required meetings remained//2006//

Denali KidCare (Children's Health Insurance Program)
Alaska's S-CHIP program, Denali KidCare, was implemented on March 1, 1999. Alaska chose to expand its Medicaid program to maximize services with the primary focus centered on outreach and enrollment of children. By the end of the first federal fiscal year (7 months from the program's

inception), the Medicaid program as a whole saw an increase of 7,130 children enrolled (58,266 in FFY98 to 65,396 in FFY99). S-CHIP enrollment (Title XXI) was 8,033. By the end of its first full year of operation, the program had exceeded its three-year enrollment goal of 11,600 children. /2002/ 13,143 children were enrolled in Denali KidCare in June 2000. The Children's Defense Fund in its report "All Over the Map" ranked Alaska number one in the nation for the rate at which the state was enrolling S-CHIP and Medicaid children.
/2003/ The monthly average number of enrolled Title XXI eligible children during the past year was 12,000; in April 2002, 13,200 were enrolled. The monthly average number of pregnant women enrolled during the last year was 2,900; in April 2002, 3,300 were enrolled.
/2004/ The monthly average number of enrolled Title XXI eligible children during the past year was 12,195; in April 2003, 12,089 were enrolled. The monthly average number of pregnant women enrolled during the last year was 3069.//2004//
/2005/The monthly average number of enrolled Title XXI eligible children during the past federal fiscal year was 11,308; in April of 2004, 12,159 children 0-21 were enrolled. The monthly average number of pregnant women enrolled during the last fiscal year was 561. The number previously reported were not accurate as they represented a total number of women enrolled as a total moving average as opposed to a per month number enrolled.//2005//
/2006/ For federal fiscal year FFY04 (10/01/03 to 9/30/04) there were an average of 11,397 children 0-21 enrolled for Title XX1. Enrollment for the Family Medicaid Title XIX program has increased however.//2006//

B. AGENCY CAPACITY

The overall program capacity of MCFH has increased over the past year and is expected to continue. The redesign of MCFH databases to make them relational and allow for greater transference and sharing of information; the building of new systems to better track program indicators; the integration of programs into the Section (i.e., the Breast & Cervical Health Check Program) and the hire of a Pediatric Epidemiologist are all measures which have positively impacted program capacity. In the upcoming year, further integration of programs (i.e., the Teen Pregnancy and Parenting Program, currently housed in Juneau, Alaska) and increased federal support for specific MCFH efforts (i.e., the FAS Program) will allow for continued capacity building through more seamless delivery of services and greater collection, management and warehousing of data.

/2002/ In 2001, MCFH increased its capacity in many Units: the FAS Surveillance Project in the MCH Epidemiology Unit added two medical records abstractors and a statistical clerk; a new medical records abstractor position was also established in the EPI Unit in support of the birth defects registry; a program coordinator position was established and filled for children's behavioral health; a program manager for newborn metabolic screening and a teen pregnancy prevention specialist position were also established and filled. The Section underwent some reorganization to establish a Data Management Unit within the Administrative Unit which houses all of the analyst/programmer positions supporting Section programs such as WIC, Healthy Families and Early Intervention. And finally, the Section established a Child Health Unit which will house the Healthy Families Program, Dental Health initiatives, and other child health programs. The Epidemiology and Evaluation Unit was re-named the MCH Epidemiology Unit.

/2003/ The Section grew dramatically in August 2001. The source of growth was the re-organization of the state Medicaid Services Unit. Twelve positions from this unit, formerly housed in the Public Health Director's Office, were incorporated into the Section. The Children's Health Unit, established in July 2001, incorporated most of the positions including six professional positions focused on statewide outreach for Denali KidCare (Alaska's child health insurance program), two professional positions which support the State's EPSDT program, a clerical position to support EPSDT and one position supporting the oral health program. Two data positions were incorporated into the Section's Data Management Unit. Three of the twelve transferred positions are located in Juneau, one in Fairbanks, and eight in Anchorage. The Section also incorporated an additional health program manager position as a result of other reorganization in the Public Health Director's office. The position, which focuses on special projects, is located in Juneau but is part of the Children's Health

Unit based in Anchorage. A new position established in the Section in FY02 was a Public Health Specialist position in the Women's and Adolescent Health Unit to provide technical assistance to providers for Family Planning and the Women's Comprehensive Care Initiative. Coordination between and integration of the Anchorage and Juneau offices takes place in many forms including: weekly Unit Manager meetings; individual unit staff meetings; distribution of unit and Section weekly reports; regular travel by the Section Chief, Data Management and Children's Health Unit Managers to Juneau; integrated monthly All Staff meetings; unrestricted e-mail and phone use; a monthly Section newsletter distributed to staff; and team building activities.

/2004/ Alaska's state health agency, the DHSS has developed significant capacity to serve women and children from prenatal care and birth through adolescence and adulthood; and including health care services for CSHCN. This capacity has been built on the foundation of strong partnerships and collaboration among federal programs, the state, and Native health care systems community-based organizations. Capacity building begins with recognizing critical issues the state faces in providing comprehensive care. For example as a result of the geographic isolation and low population density, providers in Alaska have determined the concept of "medical home" for Alaskans requires a broad definition. In many frontier areas, medical services are limited to a small clinic staffed by a Community Health Aide with basic training in primary, preventive and emergency medical care. Itinerant public health nurses visit most of Alaska's rural communities providing the "medical home" for many of Alaska's children and families. An R.N., Nurse Practitioner, Community Health Aide or Physician's Assistant provides primary and preventive care in many cases. Due to chronic staff shortages, unpredictable weather, and high cost of travel, villages and communities may receive a visit from an itinerant Public Health Nurse as frequently as monthly or as infrequently as bi-annually. The inability to access specialty care poses significant hardships for CSHCN. A coalition of state and private agencies arrived at a definition of "medical home" for Alaska CSHCN: The medical home is where a child with special health care needs and his or her family can count on having medical care coordinated by a health care professional they trust. It is not a building, house or hospital, but rather an approach to providing quality and coordinated services. Primary health care providers and families work as partners to identify and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Working from this base, a coalition of providers are currently engaged in building a base of specialists and sub-specialists in children's health, holding specialty clinics in rural communities, coordinating specialty care with families either on an iterant basis or helping families access services in larger communities. Community-based services are integral to a comprehensive system of care in Alaska. The state offers grants to local health care providers and organizations to deliver direct services to women and children. These grants build health care capacity at a local level by supporting local expertise and health care facilities as well as supporting the economic base of small communities with jobs and career options for local populations. Direct grants to local communities are available for Infant Learning Programs, WIC, Healthy Families, school-related initiatives, family and community nutrition, breast and cervical cancer screening outreach and oral health. These locally based efforts are also important to bring culturally competent care to predominately Native communities found in remote and frontier areas of the state. For example, the state supports training and education programs, some through the University of Alaska distance delivery or on-campus programs, to educate and train paraprofessionals to deliver WIC, Infant Learning, community health aides, and professional services such as nursing, early childhood teachers and others.The health of newborns and young children is another capacity building effort important for the state health agency. Outreach efforts through the SCHIP program, Denali KidCare, have been instrumental in enrolling pregnant women in the health insurance program so they can access needed services. The EPSDT program promotes important prenatal care and provides outreach so newborns can be enrolled in Denali KidCare soon after birth. Health information is provided on a regular basis to Medicaid/Denali KidCare recipients on well-child exams, health and safety and how to access medical care through Medicaid enrolled providers. All of these efforts require partnerships between the various state agencies administering the programs, local providers and local program administrators. The Section of MCFH administers a comprehensive program for newborn metabolic and hearing screening. Metabolic screening is required by state law and all newborns are screened with follow-up health care services and long term medical care coordination offered for all newborns diagnosed with a metabolic disorder. The state has also introduced legislation

to require all newborns receive hearing screening and is building the capacity in partnership with hospitals and private providers to ensure all newborns are screened and follow-up diagnostics and treatment is available for all children who do not pass the initial screens. This newborn screening initiative has been an important and successful partnership between the state, local hospitals, specialty providers and advocacy organizations to provide a comprehensive system of care for children with hearing impairments. One of the states most active community-based health care systems is the Alaska Public Health Centers. The state currently supports Public Health Centers in 23 communities and offers itinerant services to remote/frontier communities that do not have a health center. The Public Health Centers are staffed by Public Health Nurses and the Division of Public Health, Section of Nursing oversees staffing of the centers. The Section of MCFH and Nursing have long been partners in identifying and providing needed services for the MCH population. For example, family planning services are offered at Public Health Centers and contraceptives purchased with MCH block grant funds support that effort. Public Health Centers and Public Health Nurses are also the state's frontline providers of prenatal care, immunizations, referrals for specialty care, EPSDT services, maternal health services, etc. Over the next year, Alaska will be addressing significant funding issues that may affect the state's capacity to provide services to women and children. Currently the state is evaluating the effect of budget reductions on several MCFH programs. However, at this time budget reductions are unknown. //2004//

/2005/ The reorganization of the Department of Health and Social services and the resulting changes for what had been the Section of Maternal, Child and Family Health have provided many challenges and opportunities for the staff who provide services and manage and/or oversee programs for pregnant women, teens, children and their families. Programs have experienced a decrease in their capacity to maintain their programmatic databases. Programming support has been negotiated for part of this fiscal year, but with the reorganization of all information technology staff into a centralized department, future support is uncertain. New systems of communication between reorganized and new divisions and their programs are beginning to take shape. Assisting the divisions to think about the needs of the MCH population has required more overt efforts than in the past. These ongoing efforts will be critical as MCH staff move into the work of the five year needs assessment. The reorganization has provided the opportunity to strengthen new and existing partnerships. As an example, work on the Prematurity prevention campaign with the March of Dimes has helped to forge new relationships with the University of Alaska Anchorage, the business community, and new providers. Although MCH programs specifically will not experience funding cuts in the coming state fiscal year, the state's public health nursing centers will be experiencing significant budgetary challenges in the next state fiscal year which will impact their delivery of core public health services. How these changes might affect the services delivered in collaboration with our division has yet to be determined as the budget has not yet been signed. The use of Block grant funds to assist as a gap filling measure has been proposed //2005//.

/2006/ This last fiscal year was one of sorting out responsibilities, developing new relationships and reporting structures, and planning for another organizational change. Staff responsible for MCH programs took on additional responsibilities within the Division of Health Care services, providing consultation and feedback in the area of Medicaid providers services, including dental, family planning, prevention and primary care services, and treatment services such as audiology, speech-language; laboratory billing and payments; regulations regarding services for children; transportation program changes; the Medicaid waiver program and several others. Enhancing the Medicaid staff's level of knowledge around public health effects of their policy or payment decisions was very rewarding and provided an opportunity for mutual respect and understanding. As a result, the transition of working in the Division of Health Care Services was positive and enabled the MCH support prevention and primary care services from a policy and payment perspective. The most significant challenge of the reorganization was the loss of personnel capacity to take on new public health projects or respond to new grant opportunities. With the loss of staff positions and the lack of connectivity to prior programs, such as early intervention and WIC, the ability to maximize resources, both capital and personnel, became more difficult. FY04 was a struggle to gain recognition of MCH programs and voice. As mentioned earlier, the new division director of

Public Health was instrumental in assisting the MCH programs in gaining their "voice" once again with the approval to move the programs back to public health and with the development of the Section of Women's, Children's and Family Health (WCFH).

Since October of 2004, the newly appointed Section Chief of WCFH (Title V/CSHCN Director) has reported to both of the directors of Health Care Services and Public Health. This has enabled the two directors to work collaboratively on projects, maximize personnel capacity in terms of expertise and be more aligned in policies, for example in the areas of transportation to medical appointments for children (a big expense in the Medicaid budget due to lack of access in many rural villages). They have also worked together specifically on solving the care needs of children who are Medicaid beneficiaries who require specialized care not available in the state. A collaborative quality improvement project is also being jointly co-sponsored by both of the directors on the issue of timely discharge for medically fragile children from the NICU. These collaborative efforts have greatly enhanced the capacity to meet the needs of particularly children with special health care needs. Through the efforts jointly engaged in by both divisions, payments for preventative and primary care services for pregnant women and children have been supported. Data provided by the MCH Epidemiology program assisted in supporting the Medicaid staff's desire to maintain benefits including dental care for pregnant women, and staff were able to articulate more clearly the benefits of prenatal care when questioned by legislators. In addition, ongoing support for the EPSDT program resulted in an expansion of services and payments of OT, PT, Speech-Language and Audiology services to schools that enrolled as providers of Medicaid. Nearly 50% of the children in Alaska are enrolled in the Medicaid program and many have special needs. Enhancing the payment methodology for schools will hopefully provide for increased funding to hire additional needed specialists and provide services for children who qualify for an Individual Education Plan (IEP). Working together, the Title V/CSHCN director and Medicaid staff developed and initiated this program in time for the new school year that started in September of 2004. Planned increases for staffing will be minimal due to the financial situation of the MCH programs, however, a perinatal nurse consultant or program manager position paid through the MCH block grant, will be established and hired this fiscal year to increase the capacity of work on perinatal and neonatal issues that are present in our state as well as continue to improve on things that are going well. At the present time, the only person in the section with this expertise is the Section Chief. This priority hire was a result of recommendations and priorities that came from the MCH 5 year needs assessment

Positions in the reformulated section will be located in both Juneau, the state capitol and Anchorage in four locations. The Section Chief plans to move the staff from the Women's Health Unit to the location where the Children's Health Unit is currently housed with Medicaid. This will provide for an increase in communication and collaboration between the two units. Due to I.T. issues, the MCH EPI unit will stay where they are presently located. Unit meetings are conducted monthly and all staff meetings occur quarterly. Ongoing email communication occurs with staff and there is a nearly daily presence of the Section Chief in all of the staff locations with the exception of Juneau. The Section Chief travels to Juneau on a monthly basis to meet with the Oral Health Manager and Director's office staff as well as the other Section Chiefs//2006//.

C. ORGANIZATIONAL STRUCTURE

Organizational charts for the State Health Department, Division of Public Health and Section of MCFH can be found under Other Supporting Documents. The MCFH Organizational Chart includes positions by program, as well as job classification.

/2004/Alaska's state health agency, the DHSS is one of 15 Departments comprising the Executive Branch of Alaska's state government. The Governor directs the activities of each of these departments through an appointed cabinet level commissioner. The DHSS organizational structure is

broken down into Divisions with an appointed director to oversee all activities for their Division. The Division of Public Health within the DHSS has been charged with primary responsibility for MCH programs. An organizational chart for the overall reorganization of the Department of Health and Social Services is attached.

As of July 1, 2003, a major reorganization of the DHSS will change the administration of Title V funds and MCH programs. The DHSS will continue to act as the state health agency. Oversight of Title V funds will shift from the Division of Public Health to a new Division, the Division of Health Care Services. The Title V Director will be transferred to and housed within the Division of Health Care Services as the former director is being transferred to the Office of Children's Services. As previously noted in the narrative, specific MCH programs previously consolidated within the Section of MCFH/Division of Public health will be dispersed to new or existing Divisions.

Organization charts for the DHSS and each of the Divisions housing MCH programs are currently being developed and reviewed. It is anticipated that official organization charts for FY04 will not be available for including in the grant application; however, they may be available at the time this grant application is reviewed. New directors have been appointed to each of the Divisions that will administer dispersed MCH program elements, with the most recent appointment for the Office of Children's Services. The start date for that Director will be September 1, 2003. Each of these Directors will be responsible for building the organizational structure for their Division and it is anticipated that adjustments will be made to the draft organization charts as the directors restructure the Divisions.

Alaska differs from most states in that it does not have county health departments that function under the administrative arm of the state health agency. Alaska's health care system rather is a mix of direct state, tribal or federal, local health care agencies and private practice health care providers. The state operates local public health centers in 23 communities and offers itinerant public health nursing services for those communities not served by public health centers. Two urban communities have locally organized health departments, the Municipality of Anchorage and the North Slope Borough. Federally funded hospitals provide health care services to Alaska's military and Native populations. Additionally, health care services are provided to Alaska Natives through health clinics operated by the Indian Health Service or Alaska Native Health Corporations. Other services for MCH populations are provided by non-profit agencies using grant funds from state, federal or other non-governmental funding sources. The state, then, can be involved in providing health care services on numerous levels, as a direct service provider, through grants, or as a partner with Native, federal and private health care organizations in the planning, provision and coordination of health care services.

For those programs funded by the Federal-State Block Grant Partnership budget, the state's administrative role is as follows:
1. Infant Learning Program: This program has been under the Section of Maternal, Child and Family Health; it is moving to the Office of Children's Services on July 1, 2003. The state general funds spent on this porgram provide the bulk of the state match for the Block Grant and much of the state portion of the federal-state partnership. While the Department of Health and Social Services is the umbrella organization to both the Title V administrative organization (i.e., Division of Health Care Services) and to the Office of Children's Services, there will be more coordination effort required in the future to provide information required for the Block Grant application. For example, it will be more complicated to track ILP expenditures in support of the MCH-related populations and initiatives. We are not sure at this time how we will work out reporting for the Block Grant application requirement of expenditures by level of the pyramid and by population group.
2. All other MCH-related initiatives not moving to Health Care Services on July 1, 2003: These programs and functions include data management and evaluation, maternal and child health surveillance, child health indicator tracking, adolescent health, family violence prevention, and some administrative functions. MCFH has been, but will no longer be, responsible for a large portion of work previously associated with the federal-state partnership after July 1, 2003. State general funds have been used by the Section to support a variety of initiatives and personnel costs for work done relevant to Title V and which were considered in our Title V grant application. While we anticipate most of the

work to continue and that collaborative efforts will occur, it will be very difficult to track the state funding being spent in Divisions outside of Health Care Services and to track how the expenditures support MCH populations and levels of the pyramid. MCH Block Grant funds will continue to be used across Divisons to support many important functions and initiatives for our target populations.//2004/

//2005/As of July 1, 2003, a major reorganization of DHSS changed the administration of Title V funds and the MCH programs. DHSS has continued to act as the state health agency. Oversight of the Title V funds shifted from the Division of Public Health to the Division of Health Care Services. Since that time, a new Title V/CSHCN director has been named as the former Title V director became the Deputy Director of Health Care Services. As outlined in the section "Other MCH Capacity", MCH programs have been dispersed to new or existing divisions. Brief biographical sketches of the Title V/CSHCN director and other senior level management employees are attached.

For those programs funded by the Federal-State Block Grant Partnership budget, the state's administrative role is as follows:
1. Early Intervention/Infant Learning program: The program now resides in the Office of Children's Services. The state general funds spent on this program provide the bulk of the state match of the Block Grant and much of the state portion of the federal-state partnership. While DHSS is the umbrella organization for both the Title V administrative organization (i.e. Division of Health Care Services) and the Office of Children's Services, there will need to be a coordinated effort to provide information required for the Block Grant application both programmatically as well as fiscally.
2. Other MCH related initiatives that did not move to the Division of Health Care Services included data management and evaluation, maternal and child health surveillance, child health indicator tracking, adolescent health, family violence prevention, WIC and Family Nutrition, Healthy Families Home visitation program, and some administrative functions.
As stated previously, this last year has been a year of transitions. With the changes that ensued as a result of the reorganization, there has been a significant change in the sphere of Title V administrative and programmatic oversight by the Title V director. Much of the work previously done by the section of MCFH is now conducted in other divisions managed by separate directors with differing agendas and priorities. In addition, a significant amount of turnover in personnel has occurred affecting the historical knowledge that once existed. Further turnover is expected in this next fiscal year. //2005/

//2006/ During SFY04, DHSS continued to act as the state health agency. The responsibility for some of the state's MCH Title V program and the position of Title V and CSHCN director remained in the Division of Health Care Services. Decisions regarding funding allocations for the FFY05 Title V grant were ultimately made by the assistant commissioner with significant input form the Divisions of Public Health, Health Care Services, and the Office of Children's Health. Programs dispersed to the Division of Behavioral Health, that of the Children's Behavioral health project and the Resiliency project were not included in funding considerations.

As of October 8, 2004, the current CSHCN director was promoted and appointed the Title V director role. In addition with the approval by the commissioner of DHSS to move the MCH programs that currently resided in the Division of Health Care Services back to the Division of Public Health, a new section within the Division of Public Health called Women's, Children's and Family Health was created. See the biographical sketch for the new Title V/CSHCN director. For those programs funded by the Federal-State Block Grant Partnership budget, the state's administrative role is as follows:
1. Early Intervention/Infant Learning program. This program resides in the Office of Children's Services for FY05 and will continue to be located there for FY05. The state general funds spent on this program provide the bulk of the state match of the Block Grant and much of the federal-state partnership. While DHSS is the umbrella organization for both the Title V administrative organization (i.e. the Division of Health Care Services for FY04 and FY05) and the Office of Children's Services, there will continue to be a coordinated effort to provide information required for the Block Grant application both programmatically as well as fiscally.
2. Women, Infants and Children (WIC) Nutrition program remains in the Office of Children's

services during FY05. There are some state funds that support this program in the form of team nutrition grants, however the bulk of funding comes from the USDA. The WIC program and the other former MCH programs continue to collaborate on activities and participate jointly on statewide committees.
3. Maternal-Child surveillance activities remained in the Division of Public Health in the Section of Epidemiology. Beginning in October of 2004, this program began to programmatically report to the newly named Section Chief of Women's, Children's, and Family Health--WCFH (Title V/ CSHCN Director). They will transfer from the Section of Epidemiology to the Section of WCFH on July 1, 2005. Family violence prevention and childhood injury prevention were transferred to and continue to reside in the Section of Community Health and Emergency Medicine. Adolescent Health and Children's Behavioral Health were transferred to and will remain in the Division of Behavioral Health. WIC, Family Nutrition, the Early Comprehensive Care Systems (ECCS) grant, Healthy Families Home Visitation program will remain with the Office of Children's Services along with the Early Intervention program. The Adolescent Health program per se was dismantled. For now the Title V Director and the administrative manager for Title X Family Planning act as the state's adolescent health coordinator contact.

The development of new working relationships in support of maintaining an MCH presence has continued to move forward despite significant staffing changes in other divisions. Ongoing efforts in this arena will continue over the coming fiscal year //2006//.

D. OTHER MCH CAPACITY

For years 2002, 2003 and 2004 submissions, please see attachement.
//2005/ As of July 1, 2003, the major reorganization of DHSS changed the administration of Title V funds and of the MCH programs. DHSS has continued to act as the state health agency. Oversight of the Title V funds shifted from the Division of Public Health to the Division of Health Care Services. Since that time, a new Title V/CSHCN Director has been named as the former Title V Director became the Deputy Director of Health Care Services. Traditional maternal-child programs are now distributed in four divisions. Each of the divisions experienced turnover this state fiscal year and many positions remain vacant or will experience a change in their position description.

Office of Children's Services (34 positions-with 20 positions to move to July 1, 2004)
Adolescent Health - 1 position-vacant-position duties to be changing; Community & Family Nutrition - 1 position-vacant; WIC/Nutrition Programs including analyst/programmer support - 20 positions-all are transitioning from WIC to a centralized IT division; Children's Initiatives/Special Projects - 1 position-change of duties to focus on transition of 18 year olds from state custody to adult status; Infant Learning Program including analyst/programmer support - 4 positions; Healthy Families Alaska - 2 positions-Grants/contracts administrator - eliminated; Nutrition and ILP Unit Managers - 2 positions; General administrative support positions - 2 positions; Public Health Specialist - 1 position - vacant
Division of Public Health, Section of Community Health and Emergency Medical Services; Alaska Family Violence Project - 2 positions; Child Injury Prevention - 1 position
Division of Public Health, Section of Epidemiology (20 positions with two to move July 1, 2004)
Administrative Support - 4 positions; Epidemiology and Evaluation - 14 positions- total; PRAMS - 2 positions; FAS Surveillance - 3 positions; Birth Defects Registry - 3 positions; Child Health Indicators Project - 1 position; Maternal Mortality/Child Fatality - 1 position - vacant; Administrative Support - 1 position; MCH indicators surveillance project - 1 position - soon to be vacant; MCH EPI Unit Manager - 1 position; Medical Epidemiologist - 1 position; Programmatic Analyst/Programmer IV - 2 positions - moved to centralized IT division

Division of Health Care Services (30 positions with four to move to a centralized division July 1,

2004))
Breast and Cervical Cancer Screening including analyst/programmer support - 8 positions. Three positions will move to the centralized IT; EPSDT - 2 positions; Family Planning - 1 position; Genetics Program - 1 position; Newborn Metabolic Screening - 1.5 positions; Newborn Hearing Screening - 1.5 positions; Oral Health - 2 positions (1 in Juneau; 1 in Anchorage); Specialty Clinics - 1 position; Women's Comprehensive Care - 1 position; Administrative Support - 8 positions; Deputy Director - 1 position; Unit Managers - 2 positions - one of which is the Title V/CSHCN director.
MCH capacity is located in the Division of Health Care Services, however with a continued decrease in positions, the capacity to respond to new MCH initiatives has been and will continue be effected. Specific effects of these reductions are difficult to predict. However, assurances have been given by the DHSS Commissioner and new Division Directors that MCH programs will continue as they have with the same level of commitment from management, and with the expectation that the same high level of services will be available to Alaska MCH populations. //2005//

/2006/ Prior to the start of fiscal year FY05, a new public health director was hired. The new Director, Dr. Richard Mandsager was well known in public health circles as a local pediatrician with Southcentral Foundation-a health arm of Cook Inlet Tribal Association and former administrator of the Alaska Native Medical Center. In addition, he had been an active participant in a variety of MCH projects and committees prior to the change in administration. One of his goals joining the administration was to work toward reformulating an MCH section and evaluate what made the most sense in terms of transferring programs back to public health. With the assistance of the former mangers in the MCH programs and the former section chief, a proposal was presented to the Commissioner for his consideration in September of 2004. The proposal was approved in October of 2004. A new section chief (Title V/CSHCN Director) was appointed and the former MCH programs that resided in the Division of Health Care services as well as the MCH Epidemiology program (then in the Section of Epidemiology, Division of Public Health, began to programmatically report to the new section chief who reported to Dr. Mandsager. The new section name is the Section of Women's, Children's, and Family Health (WCFH). From October of 2004 through June 30, 2005, the Section Chief of Women's, Children's and Family Health (WCFH)-Title V/CSHCN Director has had a dual reporting relationship between the two divisions; that of Health Care Services and Public Health.

Specifically the programs that are moving back to public health from health care services include those in the Children's Health Unit--Newborn Metabolic Screening, Newborn Hearing Screening (EHDI), Specialty Clinics, Birth Defects and Genetics Clinics, Oral Health for Children and Adults; and those from the Women's Health Unit--Family Planning, and the Breast and Cervical Cancer program. In addition, the Abstinence Grant administration will transfer from the Office of Children's Services.

In January of 2005, Dr. Mandsager presented a proposal in collaboration with the Deputy Commissioner of the Office of Children's Services (OCS), to move the former MCH programs that reside in OCS back to Public Health as well. The Commissioner denied the request at the time due to the upcoming election. As an interim measure, the Division Director of Public Health, and the Section Chief of WCFH have identified projects to collaborate on with the Manager and staff in OCS over this next fiscal year. The plan is to request consideration for transfer again in the fall of 2005 as the new budget year begins to be planned for FY07. The programs that will remain in the Office of Children's Services include WIC, Early Intervention/Infant Learning program, Healthy Families Intensive Home Visitation program, Community Nutrition and the 5-A-Day program and the Early Comprehensive Care Systems grant.

Division of Health Care Services (the following positions will move July 1, 2005 to the Division of Public Health): Total of 23.5 positions:

Section Chief of Women's, Children's and Family Health (Title V/CSHCN Director) - 1 position

Newborn Hearing Screening - 1.75 positions; Newborn Metabolic Screening - 1.5.positions; Genetics and Birth Defects Program - 1.5 positions; Pediatric Specialty Clinics - 0.75 positions; Oral Health - 2.5 positions (1 in Juneau and 1.5 in Anchorage); Unit manager position - 1 Vacant (the second position was re-classed for the Title V/CSHCN Director position); Breast and Cervical Cancer Screening program - 7 positions; Family Planning - 1.5 positions; Administrative Support - 5 positions.

As of July 1, 2005, the EPSDT program will remain a part of the Division of Health Care Services. In addition the Women's Comprehensive Care Grant ended. This position took over Family planning full time. In addition the position of Deputy Director stayed in the Division of Health Care Services.

The Division of Public Health, Section of Epidemiology, MCH Epi program will transfer to the new Section of WCFH as of July 1, 2005. Total of 14.5 positions. To be decreased to 9 positions by March of 2006.
Administrative Support - 1 position; PRAMS - 2 positions; Alaska Birth Defects Registry (ABDR) - 3.5 positions - this program has lost its' funding and will be reduced to a .75 research analyst position as of August 1, 2005; Pediatric Epidemiologist - 1 position; Maternal-Infant Mortality Review committee - 1 position; Child Health Indicators Project - 1 Vacant. The focus of this position will be rolled into the MCH Indicators Surveillance position. This position will remain unfilled due to loss of funding; MCH Indicators Surveillance position - 1 Vacant position; MCH Epidemiologist - 1 position; FAS Surveillance - 3 positions. This program has lost funding and will be reduced to two full time positions starting in March of 2006.

Division of Public Health, Section of Community Health and Emergency Medical Services. Total of 3 positions related to MCH Block grant activities; Alaska Family Violence Project - 2 positions. Will be reduced to 1 position as of 7/1/2005. Child Injury Position - 1 position.

Office of Children's Services: Prevention Services. Total of 19 Community and Family Nutrition Services - 1 position; WIC Nutrition Programs- 10 positions total between Anchorage and Juneau.; Early Childhood Comprehensive Systems Program - 1 position; Early Intervention/Infant Learning Program - 3 positions; Healthy Families Alaska - 1 position; Unit Manager - 1 position; Administrative Support - 2 positions.

All of the Information Technology positions (analyst programmers, web masters, etc.), administrative assistants, accountants, and grants and contracts administrators were centralized under one Division of Financial Management services reporting to the Assistant Commissioner of DHSS. Previous to SFY05, these positions were decentralized to the divisions and sections and programs of the department

E. STATE AGENCY COORDINATION

/2002/ The Section of Maternal, Child and Family Health is well known for its collaborative approach to systems development, implementation and service delivery. The Section has numerous relationships with a variety of agencies and groups in order to achieve its mission. Some of our partners with whom we have collaborative working relationships and examples of the related initiatives include:
1. Other Sections within the Division of Public Health such as Nursing, Community Health and Emergency Medical Services, Vital Statistics, Medicaid Services (women's health; injury prevention and chronic disease prevention; adding newborn metabolic and hearing screening data to electronic birth certificates; S-CHIP)
2. Other Divisions within the Department of Health and Social Services such as Juvenile Justice (Adolescent Health Advisory Committee); Mental Health and Developmental Disabilities (Early Intervention; children's behavioral health)

3. The Department of Education and Early Development (Asset building for adolescent health; Building Blocks Initiative to improve the health and well-being of young children, prenatal through age 8; training)
4. Other state agencies such as the Mental Health Trust Authority and the Governor's Council on Developmental Disabilities and Special Education (funding and systems issues for CSHCN)
5. Private physicians and health care providers, local health departments, private non-profits, private and federally funded hospitals (All Alaska Pediatric Partnership; delivery of breast and cervical cancer screening and diagnostic services; family planning services; specialty clinics; FAS surveillance; early hearing detection; newborn metabolic screening; WIC)
6. Our community-based grantees (non-profits, local and Native health agencies) who deliver services such as Early Intervention, WIC, Healthy Families, Breast and Cervical Cancer Screening Outreach (training, policy development and implementation; data systems)
7. Health-related organizations such as the March of Dimes, the YWCA and American Cancer Society (folic acid campaign; breast and cervical cancer screening; cardiovascular health) and Stone Soup Group (CSHCN issues)//2002//
/2003/ No change//2003//
/2004/ One of the challenges of the reorganization of DHSS is to develop a process and/or mechanism for collaboration at all levels. Certainly the spirit of collaboration supports the goals of the department's reorganization to promote program efficiencies, reduce duplication of effort and provide customer satisfaction. As the DHSS begins the process of reorganization, program staff will continue to maintain relationships and help to establish a process for continued collaboration. However, it is unknown at this time the level of collaboration that will be established. In addition, as current MCH program staff transition and turnover under new divisions, the history and perspective of past relationships will be lost and difficult to re-establish.

Following is a description of the current level of coordination and collaboration between the MCFH and their partners that will serve as a standard in the future.

The Section of MCFH has had a rich and respected history of collaboration with partner programs within state government, at the federal level, and within Alaskan communities. The Section is grounded in the philosophy that strong partnerships and a collaborative approach are critical for systems development, implementation, service delivery and ultimately achieving the mission of the Section.

Essential MCH programs have in the past been co-located within the MCFH Section, including: WIC, CSHCN programs, EPSDT, SCHIP outreach staff (Denali KidCare), family planning, maternal health, adolescent health, oral health, child/family abuse and neglect prevention programs.
The Section has also built a necessary and highly valued data support structure. Functioning as a team, these programs have been able to develop and support a statewide, comprehensive array of services for MCH populations. As a Section within the Division of Public Health, MCFH has had daily contact and close working relationships with Public Health Nursing, Epidemiology, Community Health & Emergency Medical Services (CHEMS) and Vital Statistics. Each of these sections have supported MCH through data collection and analysis, providing direct health care services, extending prevention and treatment services for MCH populations.
Close working relationships have also been maintained with other Divisions within the DHSS. These include:
1. Division of Juvenile Justice through the Adolescent Health Advisory Committee
2. Division of Mental Health and Developmental Disabilities through early intervention programs and the children's behavioral health initiative
3. Division of Family and Youth Services through several initiatives including Children of Incarcerated Parents, foster parent health care support, Health Passport initiative for children in state custody
4. Division of Alcohol and Drug Abuse through Adolescent Health Program and Youth Developmental Assets

MCFH has also played a lead role in bringing together partners from other state departments and actively participating in program activities generated by those departments. These include:

1. The Department of Education and Early Development provides direct funding and program administration for Head Start, preschools, child care and public schools. These programs provide an opportunity to increase immunization rates, enroll eligible children in SCHIP/Medicaid, provide important health information, promote well child checkups and provide behavioral health services and services for CSHCN. The public school systems are also an essential vehicle to promote the health of adolescents. Staff from MCFH actively participates in program planning and service delivery for these programs. In addition to these on-going activities, collaboration between the nutrition programs in MCFH and Department of Education was initiated this year with the application and receipt of a Team Nutrition grant and obesity grant. Two years ago the Interdepartmental Council on Early Childhood was established through a Memorandum of Understanding between the DHSS and DOE. A co-chair is appointed from each department and the Council has met quarterly with the goals of jointly developing initiatives and activities that bridge the gap between the departments and promote comprehensive service delivery and planning for children and families.
2. The Department of Public Safety has program responsibility for the Council on Domestic Violence and Sexual Assault. The Council supports a system of shelters for women and children as well as initiatives and grants for community based prevention and intervention. A strong partnership has existed between the Council and the MCFH Family Violence Prevention Project.
3. The Department of Corrections has partnered with the DHSS and private non-profit service agencies to provide services to children of incarcerated parents. This unique partnership has resulted in identifying children and resources to promote their health, custody planning, and supports through the school system.
4. A strong collaboration between the Section of MCFH and health care providers and agencies has been a priority. Staff from the Section of MCFH are active members of the All Alaska Pediatric Partnership and maintain through this organization contact with health care practitioners, hospitals, clinics and other health care organizations. The Newborn Metabolic and Newborn Hearing Screening programs have also developed strong working relationships with primary care facilities and practitioners throughout the state. Breast and Cervical Health Check, family planning and specialty clinics also promote strong links to community-based service providers.

At the community level, grantees deliver direct services for WIC, Early Intervention, Breast and Cervical Cancer Screening Outreach. MCFH staff has supported community efforts to promote and plan for the health of children and families. MCFH has also provided direct help when significant health problems have occurred in communities with limited resources. There will continue to be a commitment to service coordination efforts and to addressing new challenges of coordination in the future in light of the reorganization of MCH-related programs and initiatives. //2004//

/2005/ As a result of the reorganization of DHSS and the resulting changes for the Section of Maternal Child and Family Health, patterns of work and relationships with other divisions within DHSS changed considerably. In preparation for the actual move of personnel and programs to other divisions or sections, many meetings were held with the new division's staff assigned to manage the transferring MCH programs. This was initiated to assist in orienting them to the program, the populations served, the flow of revenue and expenses, the type of cost accounting required (particularly for block grant reporting), the type of work done, grant funding (if applicable), data needs, and so on. This work consumed the majority of the fiscal year and into the current federal fiscal year. Therefore, because energies were focused on transitioning programs and maintaining services, less energy was directed at developing new relationships. To follow is a run down of the status of relationships that had been reported on in 2004:
1. Division of Juvenile Justice: The Adolescent Health position was eliminated and thus the Adolescent Health Advisory Committee was eliminated as well.
2. Division of Senior and Disability Services (formerly the Division of Mental Health and Developmental Disabilities): This division was significantly reorganized with mental health services combining with the Division of Alcohol and Drug Abuse to form a new Division of Behavioral Health. Our work previously had focused on infant and child behavioral health. The federal grant received for planning and infrastructure building was transferred to the Division of Behavioral Health. The Title V/CSHCN director has recently contacted the program manager of this grant to offer assistance in

moving forward in fulfilling the grant's objectives. Division of Health Care Services staff recently began to work closely with staff that manages the disability waivers and children with complex medical condition waivers to streamline the process of discharges from the newborn and pediatric intensive care units and facilitate community services. In addition, former MCH staff is currently assisting in the regulation process for special medical equipment.
3. Division of Family and Youth Services. This division was renamed the Office of Children's Services (OCS) and is managed by a Deputy Commissioner. The previous initiatives of Children of Incarcerated Parents, the Health Passport Initiative and foster care health care support are not active initiatives at this time. The Title V/CSHCN director and former MCH staff work with the two programs transferred to OCS; WIC and the Early Intervention/Infant Learning program. They have focused their efforts in the area of early hearing detection and intervention, the Early Comprehensive Care and System grant, and recently renewing the 5-A-Day nutrition program.
4. Division of Alcohol and Drug Abuse. This division combined with mental health to form a new Division of Behavioral Health. Within this division is the Prevention and Intervention Unit where a new position focused on Resiliency and Youth Development resides. We are looking for opportunities to collaborate as this position and its staff member get established.
5. Work with other departments: The work formerly done in collaboration with other departments has not proceeded and in some cases has ceased as a result in the changes in goals with the new directors and commissioners. As the new administration has now begun to establish itself, the Title V/CSHCN Director and other Division of Health Care staff hope to identify and participate in opportunities to further the goals of MCH.
6. Maintaining strong relationships with medical providers and other health care professionals has remained a priority and has been possible to work on in this last year. This has come in the form of maintaining the community advisory committees for Newborn Metabolic and Newborn Hearing Screening as well as presenting potential regulation changes and Medicaid program changes. Breast and Cervical Health Check, family planning and specialty clinics also continue to promote strong links to community-based providers.
7. Finally, strong ties to other community agencies have become very important. Significant time is spent collaborating with the March of Dimes, the All Alaska Pediatric Partnership, and the Success by Six projects focused on kindergarten readiness.

As the next year unfolds and DHSS staff begins to become established in their new roles, we are confident more collaboration will occur within the department. //2005//

/2006/ The MCH programs living in the Division of Health care Services worked through the challenges of the reorganization that started in FY03 with the change in administration. Renewing relationships and in many cases establishing new or different relationships became the working operative. Staff from both the Women's Health and Children's Health units were consulted on a regular basis by the Medicaid staff especially in areas of clinical issues and in the development of regulations that would affect the populations that the MCH programs typically served. For example, regulations around Special Medical Equipment (SME) were updated and staff who manage the programs for CSHCN were instrumental in expanding items to be covered including specialized nipples and bottles for children with Cleft Lips/Palates, digital hearing aids and assistive hearing equipment for newborns and young children are a couple of examples. Clinical staff from Women's Health and Children's Health units worked with Medicaid on provider billing issues, transportation decisions for CSHCN requiring care at the major pediatric center in Anchorage or outside of Alaska, or for children requiring EPSDT exams. Consultation and management of dental treatments, home health care regulations and payments for CSHCN and pregnant women are additional examples of MCH programs working with Medicaid.
Even the decision to reformulate the MCH programs into the Section of Women's, Children's and Family Health and transfer them back to public health, has not changed the collaboration. As an example, the staff in the Women's Health developed a proposal that is awaiting approval to work with Medicaid policy staff to develop a Medicaid state plan amendment regarding the expansion of family planning services.
Other examples of relationships between other state human services agencies include:

1. Office of Children's Services (OCS)-(child protection): The two divisions collaborated together with the Early Comprehensive Childhood Systems (ECCS-HRSA grant). In addition as one of six states awarded the Strengthening Families Initiative grant by the Doris Duke Charitable Foundation, WCFH staff as representatives of public health will collaborate with the Division of Public assistance child care licensing personnel, OCS staff, private childcare resource and referral centers and early intervention programs to meet the initiatives outlined by both grants.
2. Division of Senior and Disability Services (DSDS): WCFH staff are leading an effort to improve the private sector agencies responsible for coordinated care for medically fragile children discharged from the state's two main NICU's. A steering committee consisting of staff from the Section of Licensing, Office of Children's Services, Medicaid, NICU nurse managers, Durable Medical Equipment providers (DME), early intervention program and others are a part of this quality improvement process.
3. Divisions of Juvenile Justice, Public Assistance, OCS/Child protection, and Health Care Services worked with WCFH staff to lead a process of improving the numbers of mandatory reports for statutory rape. An educational workshop developed in part by the Women's Health unit and presented by local law enforcement and child protection personnel was offered to nurse practitioners, school nurses and public health nurses as a pilot. The workshop received very positive reviews and thus more workshops are planned in coordination with community nursing education and public health conferences in FY06.
4. Division of Behavioral Health: WCFH staff has participated in a Comprehensive Mental Health Systems committee to develop strategies to meet the goal of "bringing the children home" from outside behavioral health treatment facilities. Although the focus on prevention of behavioral health issues in very young children is not present currently, this effort has allowed WCFH staff to have an opportunity to insert information regarding the importance of early diagnosis and intervention during the very yearly years as a means to perhaps prevent a need for intervention in the teen years.
5. Federally qualified health centers (FQHC): This program was moved to the commissioner's office at the start of FY05. WCFH staff has worked with them in the past to assist with systems development of infrastructure in some of the more remote communities. WCFH staff has also worked with the FQHC staff on information regarding contraception, immunizations, and care standards for prenatal, neonatal and pediatric patients. Involvement of Medicaid staff with the WCFH staff has resulted in developing a pilot plan to provide payment for case management.
6. University of Alaska-Anchorage and Fairbanks: WCFH staff is frequent lecturers in the dental hygiene, human services, nursing, child development, laboratory science and MPH programs. The Section Chief serves on the advisory program for the university's MPH program in support of the program's development and future credentialing application. In addition the UAP located at the university is a close collaborator in developing programs for CSHCN especially in the area of transition from adolescents to adulthood.
7. Division of Public Health: WCFH staff work closely with staff from the other sections including the Bureau of Vital Statistics, injury prevention programs, public health nursing, the medical examiner's office and licensing on any number of public health issues.
8. Outside partners include the March of Dimes, The Association of Women's Health, Obstetric and Neonatal Nursing, AAP-Alaska chapter, the All Alaska Pediatric Partnership, families, other non-profit organizations, such as Stone Soup, Broken Sparrow, and FACE.//2006//

F. HEALTH SYSTEMS CAPACITY INDICATORS

HSCI#1 The rate of children hospitalized for asthma (10,000 children less than five years of age). Alaska does not have legislation allowing the collection of hospital discharge billing information. As a proxy, we examined Medicaid billing information. In 1998, 246 of 10,541 hospitalizations among children less than 5 years were billed to ICD-9 codes 493.0-493.9 (proportion = 233 per 10,000 admissions). The proportions for Natives and non-Natives were 255 and 205 per 10,000 admissions, respectively. The HP2000 objective for the US is 50 per 10,000 admissions. Because asthma

admissions may be billed for under ICD-9 codes other than those evaluated, it is likely that the reported numbers represent a lower limit.
/2002/The most recent available data for this indicator showed a substantial decrease in the rate of hospitalization for asthma among Medicaid eligible children over that reported for CY 1998. This indicator was incorrectly reported last year as the rate of hospitalization for asthma per 10,000 hospital admissions. The correct figure for FY1999 is 40 hospitalizations for asthma per 10,000 Medicaid-eligible children under 5.
/2003/ This year we further refined the reporting on this indicator to better reflect the asthma hospitalization rate. The numerator is the number of unduplicated Medicaid children that were hospitalized for ICD-9 Codes: 493.0 - 493.9 during SFY2000. For FY00 there were 126 Medicaid-eligible children that were hospitalized for asthma, which gives a rate of 50.5 (126/24,929) per 10,000 Medicaid-eligible children, a slightly higher rate than reported last year.
/2004/ The rate for FY00 is updated to 60.3 hospitalization per 10,000 Medicaid-eligible children under the age 5. The rate of hospitalizations is 69.3 per 10,000 for FY01. Alaska's rate of hospitalization for asthma within this population has increased approximately 9% from FY00 to FY01.
/2005/ The methodology for reporting this indicator was changed this year. For comparability and consistency, data for years 2000-2002 have been reanalyzed and updated using the new methodology. Years prior to 2000 have not been changed due to access limitations in the Medicaid database, caution should be used in comparing those years to data after 1999. The methodology change has been documented in the technical notes.
The revised rates for 2000 - 2002 are 53.4, 43.4 and 44.6 per 10,000. The rate for 2003 is 48.2 per 10,000. Although there was a significant drop in the rate of asthma hospitalizations from 2000 to 2001 (nearly 20%), it has increased 8% from 2002 to 2003. Compared to 2000, the rate in 2003 declined approximately 10%. Data for Health Systems Capacity Indicator No. 1 "rate of children hospitalized for asthma" comes from the Medicaid Information Management System (MIMS), Services, Tracking, Analysis and Reporting System (STARS) independent hospital claims (CH) table. Claims classified within the CH table include inpatient hospitalization services and do not include claims for outpatient hospital/clinic, day treatment or emergency visits where the client was not admitted for inpatient services. Data reported for this indicator include claims for asthma which were adjudicated and paid by Medicaid. See the technical note concerning the change in personnel and the resulting new methodology for calculating these rates.
/2006/ Continuing the decline for this indicator, the rate for 2004 was 31.2 per 10,000. However, caution should be used when interpreting this significant decline as there continue to be personnel turnover that may be contributing to the year to year differences. The State has been documenting methodology and queries through technical notes, however, significant differences persist between data analysts. In order to address data inconsistencies, this year Alaska is producing a State specific manual for the Title V Block Grant application which will include documentation and detailed technical notes on methodology for all data sources and indicators that are utilized for the Block Grant. Alaska is also reviewing changing the data source for this indicator. Medicaid has been used as a proxy to estimate asthma hospitalization rates because of the unavailability of a hospital discharge database system. Over the last couple of years, Alaska has improved capacity in this area and now have a Hospital Discharge Database that includes 88% of all in-state discharges. If Alaska determines it is now more appropriate to change this data source from Medicaid to hospital discharge data, protocol and methodology will be determined over the next year with the change occurring for the 2007 BG application. The Hospital Discharge Database is discussed more thoroughly in Form 19, Health System Capacity Indicator 9A.

HSCI#2 The % of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.
/2004/ The % of Medicaid enrollees whose age is <1 year and who received at least one initial or periodic screening remains unchanged. Approximately 82% of eligible infants received at least one initial or periodic screening during FY00, FY01 and FY02.
/2005/ This measure increased to 83.1% in 2003 - 1.6% increase from 2002 (81.8%). This was not a significant change.
/2006/ No change. The indicator remains unchanged at 83.1% for 2004.

HSCI#3 The % of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.
Alaska collects Medicaid billing data. During 1998, 3,822 of 5,028 children enrolled in Medicaid received at least one initial or periodic screen (proportion = 76%). During 1998, 65 of 112 (58%) children enrolled in CHIP received at least one initial or periodic screen. For Medicaid enrollees, the HP 2000 objective for the US is 100%.
/2003/ The % of SCHIP enrollees under age one who received at least one initial or periodic screen increased in 2001 to 81.6%. Since SCHIP guidelines have been in effect, the number of SCHIP enrollees that received an initial or periodic screen before the 1st birthday has increased 30.6%.
/2004/ The % of SCHIP enrollees under age one who received at least one initial or periodic screening decreased from 82% in FY01 to 80% in FY02.
/2005/ In 2003 there was a significant decline (28.6%) in this measure, compared to 2002. The % dropped from 79.6% in 2002 to 56.8% in 2003.
/2006/ The percentage of SCHIP enrollees under age one who received at least one initial periodic screen was 74.7% in 2004 -- an increase of 31.4% from the previous year.

HSCI#4 The % of women (15-44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on Kotelchuck Index.
Birth certificates from the AK Bureau of Vital Statistics provided this information. Birth certificates may be an inaccurate source of prenatal care since this information may not be available to the person completing the birth certificate. During 1998, 8,634 of 9,920 (87%) of women 15-44 with a live birth had an observed to expected prenatal visits ratio of at least 0.80. The HP2000 objective for the US is 90%.
/2002/This indicator was incorrectly reported in the narrative for CY 1998 as 87%. It should have been 74.6% (7401/9922) in 1999. The proportion of women who had an observed to expected prenatal visits ratio of at least 0.8 (75%) showed no improvement; in fact, adequacy of prenatal care has been declining since 1994. Adequacy of prenatal care did not improve with Medicaid expansion. We have not identified any changes in measurement or recording of prenatal care that can account for the decline in this indicator.
/2003/ Trend analysis for the years 1995-2000 shows a statistically significant decline in prenatal care participation, with an annual decrease of 1%. (Prenatal care indicators were updated this year to exclude women with unknown prenatal care histories from the denominator used to calculate the level of prenatal care initiation.)
/2004/According to the AK Bureau of Vital Statistics approximately 75% of women age 15-44 with a live birth during CY2001 met the intermediate adequacy criteria of greater than or equal to 80% of observed to expected prenatal visits. This is a decline of 1.2% from CY2000.
/2005/ There has been no improvement in this indicator - the percentage continues to decline and is at an all time record low since 1995 (72.8% for 2002). Compared to 2001, there has been a decline of 2.9%
/2006/ In 2003 over three-fourths (75.8%) of women ages 15-44 with a live birth during the reporting year had observed to expected prenatal visits greater than or equal to 80 percent on the Kotelchuck Index. This is an improvement from the previous two years.

HSCI#5 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.
5A. The % of LBW infants by Medicaid payment status: While 6% of all infants were born LBW (<2500 g), 7.5% of infants whose births were billed to Medicaid were low birth weight compared to 4.9% of non-Medicaid births. The HP 2000 objective is <5% for all births; no objective has been set for Medicaid births.
/2002/ Data for Core Health Status Indicators 6A-6D is reported as single year data, so these measures showed moderate fluctuation between 1998 and 1999.
/2003/ The percent of LBW births from the Medicaid population was almost twice (1.89 times) that of the non-Medicaid population for 2000. For 1999, the disparity between these two groups was 1.52. The increase in this disparity reflects the decrease in the % of LBW births in the non-

Medicaid group - there was no change in the % of LBW in the Medicaid group. (Note: While there appears to be a large disparity between these two groups, caution should be used when drawing conclusions or making inferences, since these rates reflect only two years of data and deal with small group sizes.)
/2005/ Although the disparity between LBW births in the Medicaid and non-Medicaid populations decreased approximately 16% from 2000 to 2002, LBW births are 1.59 times more common in the Medicaid population (7.0% vs 4.4% for Medicaid and non-Medicaid, respectively). Overall, LBW births increased 5.2%, with no change in the Medicaid population. The increase is due to a 19% change in the non-Medicaid population. (Note: Caution should be used when drawing conclusions or making inferences, since these rates reflect only two years of data and are dealing with small group sizes.)
/2006/ There has been no improvement in the disparity between LBW Medicaid vs non-Medicaid births. For CY2003, 6.9% of Medicaid births were LBW and 4.4% of non-Medicaid births were LBW--making Medicaid LBW births nearly 1.5 times more common. The percentage of LBW births overall did not change from CY2002 to CY2003, with 5.8% and 5.9%, respectively.

5B. Infant deaths/1000 live births by Medicaid payment status: In 1998, the overall infant mortality rate was 5.8 per 1000 live births. This outcome was concentrated among Medicaid recipients who had an IMR of 7.5 compared to 4.5 per 1000 live births among non-Medicaid recipients. In 1995, the overall US IMR was 7.5 per 1000 live births, with large differences among different racial groups. The HP 2000 objective is <7 per 1000 live births.
/2002/ Infant death rates improved for non-Medicaid recipients, but not for Medicaid recipients in 1999. Alaska's small population size should be taken into account when interpreting year-to-year differences in infant death rates.
/2003/ The infant death rate in the Medicaid group was almost three (2.76) times that of the non-Medicaid group for 2000. The infant death rate per 1,000 live births in the Medicaid group increased between 1999 and 2000, from 7.8 to 9.4 per 1000. (Caution should be used when drawing conclusions or making inferences from these two data points, since these rates reflect single years of data and are dealing with small group sizes.)
/2005/ The disparity in the infant death rate between the Medicaid and non-Medicaid populations declined 32% from 2000 to 2003. Infant deaths in the Medicaid population are 1.89 times that of non-Medicaid. For the Medicaid population, the rate declined 25.5% from 2000 to 2003 (9.4 and 7.0 per 1,000 live births for 2000 and 2003, respectively). In Alaska, IMR is analyzed using 3 or 5-year moving averages, due to small number of events and random fluctuations that occur when examining single-year rates. Caution should be used when drawing conclusions or making inferences from these two data points, since these rates reflect single years of data and the decline is most likely an artifact of this.

5C. The % of pregnant women entering care in the first trimester by Medicaid payment status: During 1998, 82% of all pregnant women entered care during the first trimester, compared to 75% of Medicaid recipients and 86% of non-Medicaid recipients. During 1995, 81% of pregnant women in the US entered care during the first trimester. The HP 2000 objective is >90%.
/2002/ There was a slight reduction in the % of women who received early prenatal care in 1999. Overall, 78.4% of pregnant women entered during the first trimester. 73% of Medicaid and 83% of non-Medicaid women sought early prenatal care.
/2003/ Overall, 80.5% of women entered care in the 1st trimester during 2000. 74% of Medicaid recipients compared to 87.4% non-Medicaid recipients began early prenatal care. Comparing the proportions of pregnant women in these 2 groups who did not receive prenatal care in the 1st trimester (26% for Medicaid and 13% for non Medicaid recipients), we see that late initiation of prenatal care is twice as common among Medicaid women. Women with unknown prenatal health care history were excluded from the denominator when calculating the percentage for 2000.
/2005/ There has been no change in the status of early prenatal care for Medicaid and non-Medicaid pregnant women in 2002, and the overall prevalence of receiving prenatal care in the first trimester also remains unchanged (80.5%). Late initiation of care is still twice as likely in Medicaid than non-Medicaid recipients (25.2% and 12.9%, respectively).

/2006/ The percentage of women receiving prenatal care in the first trimester remains significantly lower among Medicaid recipients compared to non-Medicaid recipients (73.9% and 87.7%, respectively), showing no improvement among Medicaid recipients from CY2002. Overall, the percentage of pregnant women receiving prenatal care in the first trimester declined slightly from CY2002 to CY2003 (80.5% vs 80.1%, respectively).

5D. Percent of pregnant women with adequate (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) prenatal care by Medicaid payment status:
During 1998, 67% of all pregnant women had adequate prenatal care compared to 59% of Medicaid recipients and 72% of non-Medicaid recipients. The HP2000 objective is >90%
/2002/ This indicator was incorrectly reported in 1998. We re-analyzed 1998 data using the above definition of adequacy of prenatal care and found that 74.6% of women overall, 78.4% of non-Medicaid and 69.3% of Medicaid women received adequate prenatal care in 1998. Despite the inclusion of pregnant women in Denali Kid Care, about the same proportion of Medicaid women (68.5%) received adequate prenatal care in 1999. Findings for the overall and non-Medicaid populations were also similar (75% and 81% respectively in 1999). Prenatal care issues must be addressed in Alaska to better understand whether adequacy of prenatal care is a measurement issue or a true problem in service delivery.
/2003/ Although there was an increase in the % of pregnant women receiving adequate prenatal care in the Medicaid group from 1999 to 2000 (68.5 and 73%, respectively), there remains a disparity between the Medicaid and non-Medicaid groups. The % of pregnant women in the Medicaid group with inadequate prenatal care is 1.34 times that of the non-Medicaid group. (Caution should be used when drawing conclusions or making inferences, since these percentages reflect single years of data and are dealing with small group sizes. Figures for prenatal care were updated for all years by excluding women with unknown prenatal health care history from the denominator.)
/2005/ The disparity between Medicaid and non-Medicaid recipients has not significantly changed from 2000 to 2002 (69% and 77%, respectively). Overall, the percent of pregnant women receiving adequate prenatal care declined nearly 5% - declines of 5.5% and 3.5% for Medicaid and non-Medicaid recipients, respectively.
/2006/ Although the disparity between Medicaid and non-Medicaid recipients remains unchanged, both groups showed slight improvement in the percentage of women receiving adequate prenatal care (using Kotelchuck Index) from 2002 to 2003. The percentage among Medicaid and non-Medicaid recipients in 2003 was 72.6% and 79.8%, respectively. Overall, 75.8% of Alaskan women had adequate prenatal care -- more than 4% increase from 2002.

Summary of Health Systems Capacity Indicator #5: For all measured outcomes, Medicaid recipients fared 40-80% more poorly than non-Medicaid recipients. See attached bar graph.
/2005/ See attached bar graph.
/2006/ See attached bar graph.

HSCI#6 The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1), children, and pregnant women.
During 1999, the % of poverty level for eligibility in Medicaid and CHIP (Denali KidCare) programs are reported in the attached table. The HP 2000 objective for the US is that no American will have a financial barrier to receiving the screening, counseling, and immunization services recommended by the US Preventive Service Task Force.
/2003/ The data reported in the previous table is no longer accurate. Note the following changes: the % of poverty level to be eligible for Medicaid is 133% for infants, children and pregnant women. SCHIP expanded these numbers to 200% of poverty for all 3 groups.
/2004/ FY2000 percent of poverty for eligibility in Alaska's Medicaid and SCHIP programs was not accurately reported in the 2003 MCHB Title V Block Grant Application. Data on the percent of poverty level for coverage by Medicaid and SCHIP is now obtained from the AK Division of Medical Assistance that administers these programs. The actual % of poverty for coverage by Medicaid and SCHIP for FY00, FY01 and FY02 is the same as FY03. With the implementation of Denali KidCare (SCHIP) in 1999, the ceiling for Medicaid eligibility (Title XIX and Title XXI) was

raised to 200% of the Federal Poverty level for children and pregnant women with the exception of children above 150% of federal poverty who have other health insurance who are not eligible for coverage.
/2005/ For children age 18 and under in the Medicaid Expansion Program for SCHIP, Denali KidCare, for the period October 1, 2002 - August 31, 2003 the FPL guideline was 200%. Effective September 1, 2003 the FPL guideline for children age 18 and under in Denali KidCare was lowered to 175%, and frozen at the 2003 FPL guideline standard. For pregnant women, for the period October 1, 2002 - August 31, 2003 the FPL guideline was 200%. Effective September 1, 2003, the FPL guideline for pregnant women was lowered to 175%, and frozen at the 2003 FPL guideline standard.
/2006/ For children age 18 and under in the Medicaid Expansion Program for SCHIP, Denali KidCare, for the period October 1, 2002 - August 31, 2003 the FPL upper guideline was 200%. Effective September 1, 2003 the FPL upper guideline for children ages 18 and under in Denali KidCare was lowered to 175%, and frozen at the 2003 FPL guideline standard meaning that the FPL guidelines no longer increase with adjustments for inflation each year. For pregnant women, for the period October 1, 2002 - August 31, 2003 the FPL upper guideline was 200%. Effective September 1, 2003, the FPL upper guideline for pregnant women was lowered to 175%, and frozen at the 2003 FPL guideline standard, meaning that the FPL guidelines no longer increase with adjustments for inflation each year.

HSCI#7 The % of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
Data for this indicator come from Medicaid Services and EPSDT. The % of EPSDT eligible children aged 6-9 years who received any dental services during 1998 was 42% (5,950 of 14,057). No HP 2000 objective for this indicator exists. Two related objectives aim to reduce the proportion of children 6-8 years of age with one or more caries and with untreated caries to less than 35% and 20%, respectively.
/2002/ When the new dental health program manager is on board, a needs assessment and survey will be conducted to further address this area.
/2003/ An examination of this indicator over the last 3 years shows annual incremental improvement, with about 50% of EPSDT children receiving dental services during SFY 2001.
/2004/This indicator continues to show incremental improvement with approximately 52% of EPSDT children receiving dental services in SFY2002, showing an approximate 2% increase from SFY2001.
/2005/ There has been no significant change in this indicator - 51.6% and 51.9% for 2002 and 2003, respectively.
/2006/ In 2004, 52.0% of EPSDT children ages 6-9 received dental health services (any kind). Although the annual percent increase is relatively small for this indicator, the percent change from 1999 to 2004 was nearly 23% (42.3% and 52.0%, respectively).

HSCI#8 The % of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.
In Alaska, all SSI beneficiaries less than 16 years requesting rehabilitative services from the state CSHCN program are eligible for Medicaid. Further, Medicaid covers rehabilitative services for all eligible children (age 0-21) who are SSI beneficiaries. Even as Medicaid is expanded to the 200% of poverty level in Alaska, MCFH anticipates that this population will continue to be covered by Medicaid for rehabilitative services, thereby maximizing the use of Title V to fund other programs/services for CSHCN who are without alternative resources.

HSCI#9A The ability of States to assure that the MCH program and Title V agency have access to policy and program relevant information and data.
/2004/Alaska's MCH data capacity is improving. The state is currently working on obtaining hospital discharge data, though this will not be an MCH responsibility. We are also working on linking newborn screening data with birth certificates. In FY04, MCH will be linked with Medicaid under the new Division of Health Care Services and may have improved access to paid claims information.

/2005/ Although not at the desired 90% of in-state discharges, the Hospital Discharge Database is now available. The tribal hospitals other than ANMC are not in the database at this time - the database has approximately 85% of all discharges statewide to date. Basset Army Hospital and API are not included. We have access to some summary data from the RPMS system about the native system discharges.
/2006/ The Hospital Discharge Database continues to improve collection, currently covering 88% of all in-state discharges. As of May 2005, data is available from the system through 2003. There has been no change in the reporting of the tribal hospitals mentioned above.

HSCI#9B Data for this indicator are from the Youth Risk Behavior Survey. In AK, 37% of children in grades 9-12 reported using tobacco during the previous month. No specific HP 2000 objective exists for this indicator. A related objective aims to reduce the initiation of smoking by children/youth so no more than 15% have become regular cigarette smokers by age 20.
/2002/ 34% of adolescents in grades 9-12 report using tobacco products in 1999.
/2003/ The 1999 estimate was updated to show that 37% of 9-12th grade students report using tobacco products.
/2005/ The 2003 Alaska YRBS is available this year. This is the first year since 1995 that Alaska has had a meaningful YRBS. The 1999 survey did not include Anchorage and was not representative of the state. Compared to 1995, current tobacco use among 9-12 graders dropped significantly - from 36.5% to 19.2% in 2003 (a decline of 47%).
/2006/ The Alaska YRBS is only conducted in odd years - 2005 data will be available at the end of summer 2005. The Section of Epidemiology (DHSS, DPH) is responsible for conducting the YRBS, however, the data is available for analysis by MCH.

HSCI#9C
/2004/AK does not conduct statewide surveillance of overweight/obesity of children. Data is available through WIC, RPMS and some school districts. The state received special federal funding in 2002 for a statewide "Obesity Project" and is developing systems for monitoring childhood obesity through the Division of Public Health.
/2005/ No update.
/2006/ Childhood obesity is recognized as a serious health issue in Alaska. Reducing childhood overweight and obesity has been identified as a state priority for the 2006-2010 Block Grant cycle. Collaboration is occurring between state and local systems to address this identified need. In 2004 the Anchorage School District and the Alaska Division of Public Health collaborated to assess the prevalence of overweight among Anchorage School District children. Currently, the Women's, Children's and Family Health Section is seeking continued efforts with school districts to measure progress in this area.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Section of Maternal, Child and Family Health has developed great capacity in terms of programmatic and population-based data analysis and surveillance activities for MCH-related programs. The MCH Epidemiology Unit has been a key group in terms of supporting the MCH Block Grant requirements and initiatives of the Section, and providing the basis of accountability required by GPRA. Activities of the MCH Epidemiology Unit focus on providing reliable data through our findings and analyses to aid in program evaluation, needs assessment and policy/decision making regarding the MCH population in Alaska.

One of the priorities during FY2003 and FY2004 is to make our data and analyses available to policy makers, public health professionals, health care providers and the community through the first edition of the Alaska MCH Data Book, Maternal and Child Health Fact Sheets, Family Health Dataline publications and our website. We will continue to make this a priority in FY2005 as well.

The Alaska MCH Data Book, completed in FY2003, is intended to serve as a reference guide for statistical and epidemiological information for use in program planning and decision-making. It provides critical data on leading health status indicators and emerging issues in maternal and child health. The data book will be distributed in hard copy and also available to download from the MCH Epidemiology website. MCH Fact Sheets are produced in hard copy and available to the public on our website. These one-page publications provide quick, easy to read information on findings and analyses from our surveillance programs. Family Health Datalines are produced in hard copy and available to the public on our website. These several-page publications provide more in-depth analyses than our MCH Fact Sheets and are more data/statistically oriented.

A major accomplishment during FY2003 and on-going into FY2004 is the addition of accessible data to the MCH Epidemiology website from our surveillance programs. During FY2004 we will be focusing on a dynamic data web site that will allow users to query data tables for leading health status indicators in the MCH population.

In FY2005, despite the separation of the MCH programs, a committment to publishing data continued and through the efforts of many, an MCH data book focused on Alaska specific PRAMS data will be published. In addition, further enhancements to the web site took place to support access to MCH data for a wider audience. In addition, the pediatric epidemiologist in the MCH Epi unit assisted the Anchorage School District design a School Screening Questionnaire for asthma, evaluated the association between sexual activity related claims and abuse reports among teens enrolled in the Medicaid program and assisted the Healthy Families Intensive Home visitation program in their program evaluation. Finally, he assisted the Section of Epidemiolgoy and the CDC perform an analysis of invasive neonatal group B streptococcal disease and its relationship to adherence to management guidelines.

In FY2006, an additional MCH Data book will be published highlighting the results of the Alaska Birth Defects Registry and Surveillance system. With the reformulation of MCH programs into the Section of Women's, Children's and Family Health, we are hopeful the program will be able to regain their stride towards achieving our goals as outlined below.

B. STATE PRIORITIES

MCFH established its goals and performance measures based on the priority needs which were developed from its five-year statewide needs assessment. Focus for MCH issues has been and will continue to be on prevention and early intervention services related to areas such as family violence, child abuse and neglect, young children's behavioral health and reduction of unintended pregnancy. MCH will continue to rely upon the MCH EPI staff to support programs and monitor activity effectiveness through its development and implementation of data systems and analysis of relevant data.

State priority need #1 (reduce the rate of drug use among families, primarily alcohol intake and cigarette use) relates to State Performance Measures 3 and 4 (percentage of women who smoke prenatally and percentage of women who drink prenatally). While the Section of MCFH has no programs that directly address the issues of alcohol and cigarette use among families, the Healthy Families Alaska home visiting program, for example, has addressed these issues among participants, primarily through referrals. In addition, the MCH EPI unit collects and analyzes data through its FAS Surveillance and Pregnancy Risk Assessment Monitoring activities and collaborates, for example, with the state FAS program by providing data to be used in program planning./2005/These data analysis activities have continued this fiscal year as well //2005//.***/2006/ This was monitored again this year and remains a priority //2006//***.

Priority need #2 (reduce the rate of child abuse and neglect) relates to State Performance Measure #2 (rate of substantiated reports of harm to children). Activities of MCH programs which address this issue include the Healthy Families Alaska home visiting program and the Family Violence Prevention Project. /2005/No change. //2005//***/2006/ No change//2006//***.

Priority #3 (increase public awareness and access to services for children's behavioral health issues) relates to State Performance Measures #2 (rate of substantiated report of harm to children) and #7 (percentage of people experiencing intimate partner violence during their lifetime), and National Performance Measures #2 (percent of CHSCN whose families partner in decision-making at all levels and are satisfied with the services they receive), #3 (percent of children with special health care needs who receive coordinated, ongoing, comprehensive care within a medical home), #4 (percent of CSHCN whose families have adequate private and/or public insurance to pay for the services they need), #5 (percent of CSHCN whose families report the community-based services system are organized so they can use them easily), and #16 (the rate of suicide deaths among youths 15-19) because this state priority does not have a specific performance measure tied to it. Activities in support of it are discussed here.

A state partnership on Early Childhood Mental Health planning project was founded on the premise that healthy social and emotional development during the critical years of birth to six results in improved developmental outcomes, productivity and well-being over a lifespan and intergenerationally. As in many other states, Alaska is plagued by a lack of mental health practitioners experienced in early childhood. However, the absence of a road system, vast geographical area, and geographic isolation of Alaska's remote villages gives rise to special challenges. As a result, access to mental health services for children in this age group and their families in Alaska is conspicuously limited or absent.

The state Partnership has outlined the gaps and barriers that hinder access to appropriate mental health services. It is clear that one barrier is a general lack of awareness that very young children can have mental health concerns. One step, then, is to educate the public and policy makers about the significance of helping families and caregivers foster positive social and emotional health in young children. A second important step is forming a public and private partnership aimed at developing shared responsibility for improving the social and emotional health of young children. The state partnership involves our social services, governmental, corporate, political, educational, faith, and health care systems. This group was briefed on key national research findings and recommendations and received an overview of existing state plans that pertain to early childhood behavioral health. A needs assessment was planned in order to document strengths and challenges of the system respective to children birth to age five, and an action plan will be developed.

The aim of efforts led through MCFH has been to broaden responsibility beyond the governmental sector for public awareness, funding, and problem solving. The interagency partnership developed an action plan to generate innovative ideas that engage these and other partners in creating early environments for children that maximize their mental health. Because Alaska's barriers and gaps in services for young children are sizeable, the strategies will be a model for other states with remote and frontier communities.

Four statewide Behavioral Health Institutes were held between 2001 and 2003 and were attended by early intervention providers, community mental health providers, child care and Head Start staff, Parents as Teachers, private providers, public health nurses and child protective services staff. In March 2002 the third Institute had Jan Martner of Arizona as the guest speaker, with several Alaskan speakers offering breakout sessions. Topics covered at the third Institute included assessment tools, treatment strategies, positive behavior support, red flags and referrals, and a diagnostic classification system for infants and toddlers. This Institute also featured a description of efforts undertaken at the local level to address the behavioral health needs in the early childhood population. Total attendance at the third Institute was 171.

The third Institute was attached to the Early Years, Critical Years conference, which also featured a behavioral health strand. Topics related to behavioral health that were presented at the Early Years conference included early brain development, the media and public policy; child parent interaction therapy; infant mental health; motivational interviewing; and asset building in young children. The total number of people attending the Early Years Conference was 473. The 4th and last Institute was held in April 2003. The total number in attendance was 261.

A training and consultation program for young children's behavioral health was established. Infant Learning Programs were offered funding to use for training and/or consultation and seven funding requests were received and approved. Collaboration with other providers was encouraged. Some programs used funding to contract mental health consultants, while others organized training.

The Children's Behavioral Health Program Coordinator has been working with a collaborative project among Tlingit/Haida, an early intervention agency in SE Alaska, and the National Association for the Education of Young Children in Southeast Alaska. They received an Early Learning Opportunities 17-month grant from the Child Care Bureau to plan and implement training and research system development to improve the access and availability of mental health services in Young Children. These efforts closely parallel the activities of the statewide project, but are limited to southeast. The Program Coordinator has participated on the Regional Advisory Committee to assist with their efforts and maximize opportunities for replicating successful models.

A project scoping sheet was submitted to Division directors in DHSS outlining issues that had been raised by providers and parents. These included appropriate diagnostic instruments and categories, billing issues around Medicaid, and the ability to provide in-home rather than clinic-based services for young children. Although at this time, no action is planned that requires funding, the scoping sheet also outlines issues that may be addressed without the need for additional dollars and documents others that may be researched further at a later time.

Like many other states, Alaska is noting an increase in the numbers of children with autism. Typically these children experience very challenging behaviors, and require early intervention to ameliorate the behaviors. In an interdepartmental effort, Maternal, Child and Family Health has collaborated with the Governor's Council on Disabilities, the Division of Mental Health and Developmental Disabilities and the department of Education and Early Development to host an Autism Summit in April 2002. The Summit brought together parents, providers and state representatives to outline concrete steps that can be taken to improve services for this vulnerable group.

The Program Coordinator developed a small library of publications related to early childhood mental health and has researched what other states are doing to address early childhood mental health. The Program Coordinator also worked with a planning committee to organize a Northwest Initiative to advance the Surgeon General's Action Agenda on children's mental health. This involved a multi-state conference in the fall of 2002.

In the DHSS reorganization effective 7/01/03, the Children's Behavioral Health Coordinator position was eliminated. It is anticipated that the new Behavioral Health Services Division will assume responsibility for early childhood mental health issues.

As a result of diminished capacity to address children's behavioral health awareness and access issues after FY03, CSHCN initiatives will address this priority and related national performance measures; the family violence prevention project has worked on projects related to child witnesses; and the Adolescent Health program has promoted Youth Developmental Assets to address adolescent risk behaviors./2005/ Work in the area of Children's behavioral health has been limited this last fiscal year//2005//.***/2006/ The children's behavioral health program was transferred to the Division of Behavioral Health where the focus has been on treatment support and wrap around services for teenages. There has not been focus on prevention and for very young children //2006//***.

Priority #4 (reduce the rate of unplanned and unwanted pregnancies including teen pregnancies) relates to State Performance Measure #1 (percent of unintended births). The MCH capacity to address this issue has varied over the years with changes in funding availability. We currently support family planning and abstinence education activities./2005/ No change.//2005//.***/2006/ No change//2006//***.

Priority #5 (increase access to dental health services for children) relates to National Performance Measures 9 (percent of third grade children who have received protective sealants on at least one permanent molar tooth) and 14 (Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program). The state's MCH capacity to identify and address oral health issues has improved significantly with the availability of CDC grant funding./2005/ Significant progress has taken place this last year with the development of an oral health steering committee. A contract to conduct a baseline assessment of 2300 3rd graders across the state has been awarded. This will provide the state oral health programs with a baseline measurement of oral health status that will assist in further development of the state oral health plan.//2005//.***/2006/ the baseline assessment has been completed and the data is being analyzed at this time and will be out for public reveiw by the fall of 2005//2006//***.

Priority #6 (reduce the rate of domestic violence) relates to State Performance Measures 5 (percentage of women experiencing physical abuse by husbands/partners surrounding the prenatal period) and 7 (percentage of people experiencing intimate partner violence during their lifetime). The MCH capacity to address these issues is primarily through its Family Violence Prevention Project./2005/No change.//2005//.***/2006/No change//2006//***.

State priority #7 (reduce the rate of postneonatal mortality) relates to state performance measure #6 (percent of mothers putting their infant down to sleep on their backs) and national performance measures #1 (percent of infants screened for conditions mandated by the state newborn screening program), #3 (percent of children with special health care needs - CSHCN - who receive coordinated, ongoing care within a medical home) and #4 (percent of CSHCN whose families have adequate private and/or public insurance to pay for the services they need). The state MCH program's capacity to address this priority has been through its newborn screening program, CSHCN activities, review of epidemiological data and information from the Maternal Infant Mortality Review which is provided to programs, health care providers and communities for program planning and education that focus primarily on prevention-related activities such as the Back to Sleep and Never Shake a Baby campaigns. This issue has been heavily focused on over the last couple of years. The state has actively engaged all of the birthing facilities to participate in the national education campaign around many of these issues./2005/ Work programatically has been more limited as a result of the changes experienced with the reorganization, however many facets of the work have prevailed. Ongoing work re-establishing relationships and prioritizing the work to be done by a much smaller staff will occur in FY2005. //2005//.***/2006/ This is a departmental priority as well with a focus on injury prevention in the post neonatal period//2006//***.

Priority #8 (reduce the rate of teen suicide) relates to State Performance Measure #10 (percentage of youth who feel supported at school) and National Performance Measure #16 (the rate of suicide deaths among youths 15-19). MCFH capacity to address these issues is through its adolescent health

program, promotion of Youth Developmental Assets, and collaboration with other agencies and organizations./2005/ The focus of this work changed considerably and has transferred to the Division of Behavioral Health with the development of the Resiliency Manager. Teen suicide prevention is a priority in the current administration with dedicated staff and community partners working collaboratively. With the demise of the Adolescent Health program, there are no resources currently to dedicate to work on this issue with others//2005//.***/2006/No change//2006//***.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	97.5	97.5	97.5	97.5	98.5
Annual Indicator	99.6	99.7	99.8	100.0	100.0
Numerator	9821	9860	9809	11	15
Denominator	9861	9890	9830	11	15
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Source: Alaska, MCFH, Special Needs Services Unit. Denominator is Bureau of Vital Statistics CY 2002 occurrant state births. Numerator is number of initial newborn screening tests conducted. Due to late reporting of births to vital statistics we expect the numerator to change as birth reporting becomes more complete later this year.

Notes - 2003

Source: Alaska, MCFH, Special Needs Services Unit.

Notes - 2004

/2006 BG note: The annual performance objective will be in creased to 100 percent for the next 5 years as our state program has nearly met 100 for quite some time.

a. Last Year's Accomplishments

The percent of infants screened in the State in 2004 was 100%. The program manager continued a series of educational efforts around the state targeting medical staff involved in the collection process. These efforts included education on proper collection techniques, transport issues, and how to reduce the number of hospital discharge refusals and frequently included continuing education credits. With education of hospital staff, discharge screening refusals fell to near zero in most communities. There were only 23 discharge refusals in 2004 but even these babies were eventually screened to reach the 100% screened mark. The Newborn

Metabolic Screening (NBMS) Advisory Committee continues with a schedule of meeting three times per year to discuss issues regarding the program. These are infrastructure building and population-based activities.

A brochure designed to meet a lower literacy level was developed and prenatal providers were targeted with this information. Brochures holders were developed to hold both this brochure and the Newborn Hearing Screening brochure. These holders were sent out widely across the state to family practice physicians, obstetricians, nurse midwife providers, public health nursing centers, and any office where prenatal patients might visit. A system for refilling the brochure holders was also put in place. These are infrastructure building activities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue education and communication with providers who have high refusal rates.				X
2. Continue education and monitoring of specimen quality to assure a high level of screening is conducted.				X
3. Distribute program brochures throughout Alaska in health care offices.			X	
4. Provide community education through presentations at university programs and professional organization annual meetings.			X	X
5. Streamline follow-up tracking and referrals to expedite diagnostic testing for newborns that screen positive.			X	X
6. Refer infants identified with Sickle Cell Disease, CAH, and carnitine uptake/transport defects to state-sponsored Genetics and/or Metabolic Clinics.	X			
7. Provide information on reportable conditions to the Alaska Birth Defects Registry.				X
8. Convene the Newborn Metabolic Screening Advisory committee on a three times per year basis to develop policies and provide education.				X
9. Convene a Cystic Fibrosis Task Force to review information in consideration of adding this condition to the screening panel.				X
10. Participate in the Western States & Territories Genetic Collaborative Grant effort to improve access to genetic services in Alaska.			X	X

b. Current Activities

With implementation of expanded testing with tandem mass spectrometry on October 1, 2003, the state now tests for over 30 conditions that could adversely affect an infant's health and mental growth. Ongoing educational efforts are underway to address the issues of proper collection and lab submission for confirmatory testing. All infants identified with Sickle Cell Disease, CAH, and carnitine uptake/transport defects in 2004 were referred to the Genetics and/or Metabolics Clinic conducted by the State of Alaska. The families of children identified with these disorders need genetic counseling and advice on their child's disorder. All of these conditions are reportable to the Birth Defects Registry and information was provided to the registry. As a result of expanded testing, 14 cases of one particular carnitine disorder (called CPT1) have been identified in the Alaska Native population. The metabolic geneticists from Oregon are working with Alaska physicians to try to determine the significance of this new finding. The NBMS Advisory Committee held its regular three times per year meetings and invited guest speakers included the director of our screening lab which is the Oregon Public

Health Lab, a local pediatric pulmonologist, and a metabolic genetics specialist from Oregon Health Sciences University. The advisory committee established a smaller, separate task force to consider adding cystic fibrosis screening to the panel. The task force is currently meeting monthly to study this option and make a recommendation to the advisory committee. These are population-based, enabling, and direct health care services.

The newborn metabolic program along with the genetics and metabolic clinic program was included as part of the Western States & Territories Genetics Collaborative Grant awarded at the start of our state fiscal year. Alaska plans to use their share of the award to assess the need and capacity for genetics services in rural Alaska and develop an infrastructure to expand or meet those needs through infrastructure and system development. The work on this collaborative will continue through the next two grant years (June 1-May 31st). These are infrastructure building activities.

Finally, ongoing travel to remote hospitals in the state that deliver newborns and conduct newborn metabolic screening continued with an emphasis on specimen collection technique and working with clients who may be reluctant to have their newborn screened. Quality improvement and assurance in specimen collection, transport time from the hospitals to the public health lab in Oregon and the number of refusals are the three main quality measures monitored by this program. These are infrastructure building activities.

c. Plan for the Coming Year

We are anticipating the need for continuing education efforts regarding the lesser known conditions identified through expanded testing with tandem mass spectrometry. Most important will be to educate providers regarding the confirmatory testing process including proper specimen collection and shipment to the appropriate testing facility. Guest speakers have been invited to the NBMS Advisory Committee meetings to discuss what some of the screening results mean and if/how to treat infants identified with these disorders. Future speakers will be invited to discuss reimbursement issues for the costly diagnostic follow-up testing that is often necessary to make a final diagnosis. These are infrastructure building activities.

Integration of NBMS data with the software database purchased by the Early Hearing Detection and Intervention program is under consideration. Other plans include monitoring the Oregon Public Health Laboratory on their readiness to add CF screening to the screening panel they offer. This information will play a vital role for the CF Task Force in their consideration of adding this condition to the screening panel. These are infrastructure building activities.

Finally ongoing work with the Western States & Territories Genetics Collaborative and other children's health programs including Early Hearing Detection and Intervention program, Specialty Clinics and Genetics and Birth Defect Clinics will continue during this next year. These are infrastructure building activities.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective		57.2	57.5	59	61
Annual Indicator		57.2	57.2	57.2	
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	65	67	67	67

Notes - 2002

Source: 2001 SLATIS/CSHCN Survey, data analysis 4/03.

Notes - 2003

Source: 2001 SLAITS/CSHCN Survey

/2005/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

(On-going.) Genetics counseling services remained stable over the last three years and were provided to Alaska residents as a non-directive process. Patients were given information about the disorder, its history, testing, and treatment and recurrence risk to future pregnancies. They were supported in their decision making. Families had contact with the clinic before and after their appointments in the form of preparation. They received a medical report summarizing their genetics clinic visit and follow up letters informing them of laboratory results. Parents were given information about national (disease specific) support groups, local parent contacts, and local support organizations. If appropriate, patients were referred to other state specialty clinics for coordination of specialty care. They were given information about Denali KidCare (state CHIP program) and non-state treatment organizations such as the Muscular Dystrophy Association, Cystic Fibrosis Association, Hemophilia Clinics and Shiner's clinics. Nutritional counselors worked with parents of children with metabolic conditions (PKU, galactosemia) to assure dietary compliance and monitor monthly blood tests. The genetic counselor worked with these families to arrange formula shipments or assist them with trouble shooting insurance reimbursements. She worked with families and the school district to assure that children receive recommended school services, including special dietary needs, psychosocial assessments, special classroom placement for hearing/vision impaired, modified physical education, and special education services. These activities are direct health care and enabling services.

Cleft Palate Clinics encouraged parents of CSHCN to become more involved in decision-making through the use of Stone Soup Group parent navigators, who are also parents of CSHCN, and their distribution of educational materials. Parent navigators provided clinic preparatory and follow-up services for families who requested their support. They solicited feedback from families who attended state-sponsored clinics to determine their level of

satisfaction and delivered information packets to hospitals for distribution to parents of newborns with clefts. In addition, parent navigators conducted nursing inservices at two of the largest birthing facilities in the state to update them on feeding techniques and supportive nursers. Parent navigators assisted state staff in researching nursers that were most beneficial, and with this information Medicaid codes for reimbursement were made available. They also attended the national Cleft Lip and Palate conference in Myrtle Beach, SC, participating in sessions designed for parents and support personnel to improve access to services and the level of care provided to infants born with these conditions. These services and activities were funded through a state grant using MCH block grant dollars. These activities are infrastructure and population based services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide information to families about their genetic disorder, testing and recurrent risk to future pregnancies.	X			
2. Provide families a medical report summarizing their genetics or specialty clinic visits.	X			
3. Provide families information about national and local support groups, local parent contacts, pen pals and internet chat rooms.	X			
4. Refer patients to other clinics, agencies, or programs as appropriate for their conditions.		X		
5. Solicit feedback from parents who attend state-sponsored clinics to determine their level of satisfaction.				X
6. Provide grant funding for parent navigation services at Cleft Lip/Palate Clinics and for follow-up with families after clinic visits.	X			
7. Provide grant funding for parent navigators to make hospital visits to parents of newborns with cleft lip/palate and to deliver information packets to them.	X			
8. Survey families annually concerning their level of satisfaction with parent navigation services for Cleft Lip/Palate Clinics and what might be improved.				X
9. Contract for parent navigation services for families with newborns or infants diagnosed with hearing loss to assist them to navigate through the process of treatment and early intervention.	X			
10.				

b. Current Activities

Continuation of last years services as described above.

Public Health Clinics and public heath nurses have been an invaluable resource to their communities for many years. They play an important role in terms of coordination of specialty clinics as well. Six public health clinics host genetics clinics in hub communities around the state and a public health nurse acts as the local contact. She/he coordinates clinics in terms of scheduling patients, assisting with patient travel, medical record retrieval, and follow up with patients about genetic information received at clinic and testing to be arranged. This year HCS used Block Grant funds to pay for 1.0 FTE PHNA (public health nurse associate) in the Fairbanks clinic, which is the largest community outside Anchorage. This prevented that position from being eliminated and eased the workload at that clinic. Specialty clinic

coordination has been much more efficient and feedback from physicians and patients has been positive.

Title V Block Grant funds continue to support parent navigation services and to expand them. Parent navigators are empowering families to take an active role in making decisions about services for their children. Parent navigators publish a newsletter for parents, provide in-service training for hospital staff and make hospital visits to parents of newborns with clefts before they are discharged. They provide education materials to new parents. These activities are infrastructure and population based.

c. Plan for the Coming Year

Work is underway to reorganize the role of the State Genetics Clinics in terms of direct services and partnership with local public health nurses and local hospitals, as described in Performance Measure 3. Funding the PHNA this year has been so successful that the Alaska Genetics Clinic (together with the other state specialty clinics) is considering funding portions of other rural health centers to help them coordinate specialty clinics. This would allow other state-private contract clinics (e.g. pediatric neurology) to be moved to the public health centers which would consolidate their role in hosting community-based specialty services. Preservation of rural specialty clinics is infrastructure, population-based and enabling services.

Parent navigation services will continue. Parent navigators will work with parents at Cleft Lip and Palate Clinics, provide in-service training to hospital staff, and make hospital visits to parents of newborns with facial clefts. They will survey families to determine parent satisfaction with their services and to determine if there are additional services they can provide. In response to a request from parents, they will determine whether or not it is feasible to organize social activities for teens with cleft where they can interact with others who share their diagnosis. These are infrastructure and population based services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8	46.5	48	50	52
Annual Indicator	6.8	46.5	46.5	46.5	
Numerator	1497				
Denominator	22148				
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	54	56	58	58	58

Notes - 2002

Source: 2001 SLATIS/CSHCN Survey, data analysis 4/03.

Prior to 2004 MCHB Title V Block Grant submission, data was obtained from Alaska MCFH, Special Needs Service Unit. Data now comes from SLATIS/CSHCN Survey.

Performance Objectives for this indicator have been revised to reflect change in source data, 6/03.

Notes - 2003

Source: Source: 2001 SLAITS/CSHCN Survey

/2004/ Prior to the 2004 MCHB Title V Block Grant submission, data was obtained from the Alaska MCFH, Special Needs Service Unit. Data now comes from SLAITS/CSHCN Survey. Performance Objectives for this indicator have been revised to reflect change in source data.

/2005/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. In the past, the estimates that were reported are not comparable to the SLAITS data. We will update this measure when new SLAITS data are available.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

(On-going.) Since there are no pediatric geneticists in Alaska, HCS contracted with Seattle Children's Hospital and Regional Medical Center (CHRMC) to conduct statewide outreach clinics. The contract included services of clinical geneticists who offer diagnostic clinics for children/adults with genetic diseases, birth defects, or persons "at risk" for genetic conditions because of ethnicity, family history or age. Metabolic geneticists and metabolic nutritionists staffed metabolic genetics clinic for medical management of children/adults with inherited metabolic conditions, particularly children identified on newborn metabolic screening. These are direct health care services.

MCH block grant funds and program receipts supported certain direct care services for children attending genetic services. No one was refused services due to inability to pay. A sliding fee scale was provided based on poverty guidelines, and all third party payers were accepted. Patients referred to genetics clinic were required to have a medical home. The genetic counselor assisted them in obtaining a medical home if they did not have one. This was usually a primary care pediatrician, a family practice physician, or a sub-specialist knowledgeable in management of a specific genetic condition. The genetics clinic was a consultative clinic and did not provide primary care. Reports summarizing the genetics clinic evaluation, which may include recommendations for care and further testing were sent to the primary physician. Geneticists were available to primary physicians for consultation or technical assistance. The genetic counselor worked with local hospitals and CHRMC to assure that families were referred to appropriate community based genetics clinics following hospital discharge, or that families were aware and able to attend regional clinics (e.g. metabolic clinics) if a local clinic was not accessible. Finally, the geneticists and genetic counselor worked with families to locate and refer to out-of-state medical centers for care if no instate resource was available. These are population-based, enabling and direct health care services.

Pediatric specialty clinics worked with providers to assure that CSHCN received care within a

medical home. Since there is no craniofacial center in Alaska, the state coordinated clinics for children with facial clefts. A multidisciplinary team of health care providers offered evaluations and treatment planning. Recommendations were given to patients' parents and providers. The state also contracted with providers to offer pediatric cardiac, neurodevelopmental and neurology clinics in hub communities where these services were not otherwise available. Paper Trails notebooks were given to families of CSHCN to assist in managing medical records. Continuing education was provided on neurodevelopmental topics to staff at the rural public health center and local providers. These are infrastructure, population-based and enabling services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gather and track medical home information for every child accessing state-sponsored CSHCN services.				X
2. Use MCH block grant funds and program receipts to support genetics and specialty clinics for CSHCN.	X			
3. Assist patients in obtaining a medical home if they do not have one.	X			
4. Furnish reports summarizing genetics and specialty clinics visits to families and to their primary care providers.		X		X
5. Supply Paper Trails notebooks to families who attend Cleft Lip/Palate Clinics as needed to assist families in managing medical records.		X		X
6. Provide continuing education about neurodevelopmental topics to staff at rural public health centers and to private providers.				X
7. Assure linkages to medical homes for newborns identified with a possible metabolic disorder.			X	
8. Work with hospitals to assure that families are referred to state-sponsored clinics as appropriate.				X
9. Assure infants and newborns diagnosed with hearing loss are linked with a medical home.	X			
10.				

b. Current Activities

Continuation of services as described above.

Expanded newborn metabolic screening using tandem mass spectrometry (implemented October 2003) now detects over 40 inherited metabolic disorders. The increased number of metabolic disorders identified, and difficulties confirming those disorders that require skin biopsies, has placed increased demands on Metabolic Genetics Clinics. These are population-based and direct health care services.

The private sector now has capacity to meet the need for pediatric cardiac clinics; therefore, the state is discontinuing sponsorship of these clinics. There are presently three pediatric cardiologists in Alaska. All three are interested and willing to travel to smaller communities and provide services in conjunction with cardiac surgeons. In addition, Seattle Children's Hospital and Regional Medical Center plans to continue a pediatric cardiac outreach clinic. They will target three communities in Southeast Alaska where many of their referrals originate. A cleft palate clinic is not being held in Southeast Alaska this year as a result of input from patients and providers in that area who feel it is not necessary. Most families receive ongoing,

coordinated care for their children with facial clefts in other communities, and they are not interested in attending a state-sponsored clinic locally. These are direct health care services.

c. Plan for the Coming Year

In February 2003 CSHCN Summit (funded in part by an AAP Medical Home grant) identified two key issues/challenges for Alaska. 1) families and providers need to be aware of available services and resources and 2) there is a shortage of health care providers especially in rural areas.

As genetics and specialty clinics are transitioned from Division of Health Care Services to Division of Public Health in FY2006, they will continue to work to these goals. The current practice of providing rural and remote outreach clinics is time consuming and costly use of financial resources. None of these clinics is accessible by road and the cost of services and the costs of air transportation continue to escalate. Reassessing program resources, the program is looking toward eliminating the smallest rural clinics and/or replacing them with telemedicine services. While Alaska has limited telemedicine capabilities, there are hospital-to-hospital facilities that could be utilized as a pilot program to replace in-person clinics. These activities would use existing equipment and tie in hospital based programs such as the NICU (newborn intensive care unit). Advising rural physicians on follow up to abnormal newborn screening tests and on going care of rare metabolic disorders is anticipated to be the first uses. Clinic days, including additional days for Metabolic Genetics Clinic will be reassigned to hub centers. MCH block grant monies will continue to be used in support of this effort (direct health care services). Telemedicine will be enabling services.

Services to pediatric neurology clients will remain intact, but some responsibility for these clinics will shift from the state to a pediatric neurologist who provides services at the clinics. The state will continue providing travel reimbursement for the pediatric neurologist and will reimburse for some administrative services. The provider will no longer receive a professional fee from the state but will bill clients for clinic visits. Cleft Palate Clinics in Western Alaska and Southeast Alaska will be reviewed to determine what the state's role will be. All of the children served by the clinic in Western Alaska are beneficiaries of their local Native health corporation, and the corporation may be able to assume a greater role in these clinics. Clinics in Southeast Alaska will be revisited to determine whether or not there is a need for the state to continue sponsoring them. These are direct health care services.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	58.6	60	60	60
Annual Indicator	84.6	58.6	58.6	58.6	
Numerator					

Denominator					
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	60

Notes - 2002

Source: 2001 SLATIS/CSHCN Survey, data analysis 4/03.

Prior to 2004 MCHB Title V Block Grant submission, data was obtained from Alaska MCFH, Special Needs Services Unit. Data now comes from SLATIS/CSHCN Survey.

Performance Objectives for this indicator have been revised to reflect change in source data, 6/03.

Notes - 2003

Source: 2001 SLAITS/CSHCN Survey

/2004/ Prior to the 2004 MCHB Title V Block Grant submission, data was obtained from the Alaska MCFH, Special Needs Services Unit. Data now comes from SLAITS/CSHCN Survey. Performance Objectives for this indicator have been revised to reflect change in data source.

/2005/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Information is collected and tracked for all children accessing state-sponsored CSHCN services. CSHCN programs collaborate with the Denali KidCare and Family Medicaid programs which provide Medicaid coverage to over 50 percent of the children seen. A contract with Alaska Native Tribal Health Consortium (ANTHC) provides Indian Health Services funds as a payer of last resort for genetics and specialty clinics services. Genetics and specialty clinic services are provided regardless of the ability to pay. These activities are direct health services, enabling services and population-based services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collect and track insurance information for all children accessing state-sponsored CSHCN Services.				**X**
2. Contract with ANTHC to provide IHS funds as payer of last resort for Alaska Natives who receive specialty clinics services.	**X**			**X**
3. Provide genetics and specialty clinics services regardless of ability to pay.	**X**	**X**		

4. Work with Division of Health Care Services to expand Medicaid coverage for nutritional supplements/supplies for children with inborn metabolic disorders and those born with cleft lip/palate.		X		X
5. Continue to assure coverage for hearing aid supplies and treatment are commiserate with the Medicaid fee schedule.				X
6. Work with Blue Cross and Aetna to expand coverage of specialty health needs.			X	
7. Continue to provide the Hearing Aid Loaner Pprogram to enable deaf or hard-of-hearing children to obtain hearing aids if their families do not have third-party coverage for them.		X		
8. Collaborate with Division of Senior and Disability Services to streamline processes for CSHCN to apply for waivered services (Tefra, CCMC, CSMK).		X	X	
9.				
10.				

b. Current Activities

Insurance information is collected and tracked for all children accessing state-sponsored CSHCN services. CSHCN programs collaborate with the Denali KidCare program which provides Medicaid coverage to many CSHCN. A contract with the Alaska Native Tribal Health Consortium (ANTHC) provides IHS funds as payer of last resort for genetics and specialty clinics services. Genetics and specialty clinics services are provided regardless of inability to pay. These activities are infrastructure building, enabling and direct health care services. Based on the state data collected from those seen at any one of the state sponsored clinics < 5% of the children are without some form of health insurance coverage. However, plans vary considerable on the amount and type of coverage for specialty care and treatment (direct health care services).

In collaboration with the Division of Health Care Services EPSDT staff, efforts are underway to educate parents of CSHCN who are eligible for Medicaid benefits about the importance of obtaining well-child checks according to the periodicity schedule. Special newsletter articles are under development to be sent to organizations that support parents of CSHCN children that contain information regarding EPSDT services and a toll free number to contact for more information (infrastructure building services).

In FY05, specialty clinic staff worked with their colleagues in the Division of Health Care Services to expand Medicaid coverage for nutritional supplements and supplies for children with inborn metabolic disorders and those born with a cleft lip and/or palate. In addition, coverage for hearing aid supplies and treatment were expanded and the Medicaid fee schedule was updated to be more in line with current reimbursement schedules. Specialty clinic staff and those staff working in the newborn hearing and newborn metabolic programs also worked with the two larger health insurance carriers, Blue Cross and Aetna, to expand coverage of specialty health needs (population-based services). Finally, the hearing aid loaner program funded by a grant from the Mental Health Trust Authority has enabled children who are deaf or hard of hearing to obtain hearing aids if their family has no health insurance coverage or the policy does not cover hearing aids. The use of this program has been slowly growing as more children under the age of 2 are identified early in the newborn period with hearing loss (enabling services).

c. Plan for the Coming Year

In the coming year, state staff members of the specialty clinics and children's programs will be transferring back to public health as part of the reformulated Section of Women's, Children's

and Family Health. However, they will continue to share office space with their Medicaid colleagues and will continue to offer their clinical and programmatic expertise as reimbursement decisions are considered. In addition, the children's programs will continue to work closely with their advisory committees, all of which include both private and public health payers. The EPSDT program will also continue to provide news articles and Medicaid Recipient Helpline contact information to support organizations for parents of CSHCN (infrastructure building services).

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		73.3	79.3	75	75
Annual Indicator		73.3	73.3	73.3	
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

Notes - 2002

Source: 2001 SLATIS/CSHCN Survey, data analysis 4/03

Prior to 2004 MCHB Title V Block Grant submission data was obtained from Alaska MCFH, Special Needs Services Unit. Data now comes from SLATIS/CSHCN Survey.

Performance Objectives for this indicator have been revised to reflect change in source data.

Notes - 2003

Source: 2001 SLAITS/CSHCN Survey

/2004/ Prior to the 2004 MCHB Title V Block Grant submission, data was obtained from the Alaska MCFH, Special Needs Services Unit. Data now comes from SLAITS/CSHCN Survey. Performance Objectives for this indicator have been revised to reflect change in data source.

/2005/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Genetics clinics provided an infrastructure for linkages with many public and private agencies. These services included referrals for specialized medical assessment and/or medical care, psychometric testing for eligibility of special educational services, vision and hearing assessments, and local and national parent support groups. Genetics clinics met throughout Alaska in public health clinics and worked with public health nurses (PHNs) at the community level to provide clinic services, case management, and technical assistance to families and individuals. Annual reports were reviewed to assess attendance at specific clinic sites and practitioner referral patterns. This was to monitor service delivery and determine if sites were appropriate for changing population needs and access to care. Geneticists provided information, medical consultations and technical assistance to local physicians and health providers via MEDCON, telemedicine, Internet resources (http://www.genetests.org), and on-site continuing education presentations at grand rounds. This was particularly useful for providers in rural areas. The genetic counselor worked with a newborn metabolic coordinator to ensure that infants with abnormal newborn screening tests were referred to the metabolic genetics clinics for ongoing care as quickly as possible after diagnosis was made. To assure culturally appropriate genetics counseling and accessible community services, genetics clinics were held at two Alaska Native Medical facilities (Yukon Kuskokwim Delta Regional Hospital and the Alaska Native Medical Center). In addition, for our non-English speaking families, professional medically trained interpreters translated the genetics session for the family. Information packets about the genetics condition were provided in their language if possible. Lending libraries of audio-visual and print materials of genetic conditions were available to families. These are infrastructure building and enabling services.

Providers at pediatric specialty clinics referred to community based services as appropriate. Parent navigators who participated in state-sponsored Cleft Lip and Palate Clinics provided linkages to services, families who attended clinics were given contact information for providers participating in clinics, and the clinic coordinator provided information about community-based services. Local PHNs worked with specialty clinics to assure families were linked to services recommended at state-sponsored clinics. These are infrastructure building and enabling services.

In post Summit meeting with the steering committee, many ideas were considered in support of applying for a Champions for Progress Center Incentive Award. Initially Stone Soup Group stepped forward to act as the primary agency to request the award for expansion of parent navigation services to rural areas through a Train the Trainer model. Unfortunately, they were not able to go through with the application due to capacity issues.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue contracts to deliver genetics and specialty clinics statewide.	X			X
2. Hold state-sponsored clinics in public health centers and work with PHNs at the community level to identify and provide services to families and individuals.	X	X		
3. Geneticists and other specialty providers provide information, medical consultations, and technical assistance to local health providers.			X	
4. Assure culturally appropriate services by holding some clinics at				X

Alaska Native medical care facilities.				
5. Provide professional medically-trained interpreters to translate the genetics session for non-English speaking families.		X		
6. Provide information packets about genetics conditions in other languages.		X		
7. Continue collaboration and work with the All Alaska Pediatric Partnership to identify gaps in access to pediatric specialty services and support recruitment efforts.				X
8. Expand service delivery of metabolic clinics to areas with identified capacity needs.	X			
9. Parent navigators work with families who attend Cleft Lip and Palate Clinics and those parents with newborns or infants who experience hearing loss to assure they are linked to resources such as support groups, providers and financial aid programs.		X		
10.				

b. Current Activities

As part of the follow up from the MCH Block grant needs assessment input received from focus groups for CSHCN, and the input from the steering committee that addressed the outcomes and priorities identified in the CSHCN Summit held in February 2003, the Title V/CSHCN director plans gather members from both groups together with the goal of working towards resolution on at least one issue in FY05. The Title V/CSHCN director also will continue to actively participate in the community coalition of hospitals and medical providers serving the pediatric population of the state, called the All Alaska Pediatric Partnership. This organization is again working on identifying pediatric specialty provider needs, developing a recruitment priority list and moving ahead in developing plans for pediatric systems of care in the areas of rehabilitation and cancer care in coordination with other Outside tertiary and regional medical facilities. These activities are infrastructure-building services.

The Director of the Division of Health Care Services, Title V/CSHCN director, and specialty clinics coordinator met with the Anchorage-based plastic surgeon who performs most of the cleft lip and palate repairs for children in the state's largest community and as well as in rural communities. The state offered support in recruiting another plastic surgeon to replace his associate who moved away recently. Parent navigators are working with families who attend Cleft Lip and Palate Clinics to assure families are linked to resources such as support groups, providers and financial aid programs. Specialty Clinics Program surveys families following their clinic visits. They are asked if they can easily get services recommended at their clinic visits. An overwhelming majority indicate that they are able to. These are infrastructure building and enabling services.

c. Plan for the Coming Year

Participants in the February 2003 CSHCN Summit indicated that the key issue/challenge facing families is that accessing services is complicated and confusing. Overall recommendation is to increase access to care coordination. Summit activities fall under infrastructure building and serve the CSHCN population.

The Title V/CSHCN director will continue to actively participate in the community coalition of hospitals and medical providers serving the pediatric population of the state. Her association with the All Alaska Pediatric Partnership (an organization committed to identifying pediatric specialty provider needs and a recruitment priority list) allowed her to play an instrumental role in previous recruitment of a pediatric neurologist and pediatric oncologist. Now she will work with them to recruit a pediatric geneticist. Obvious understaffing of the Alaska Genetics

program (one genetic counselor per 660,000 population) will be eased by additional staff. The Title V/ CSHCN director will research hiring a 0.5 FTE genetic counselor to assist with immediate clinical needs of the program that have evolved with a growing population, and increasing number of genetics disorders and available testing. Underfunding issues are being addressed. Other regional medical facilities will be approached regarding the role in hosting clinics and for financial support. Changes to the state's billing will add financial viability to the service by increasing program receipts. These should allow services to transition to the private sector by FY 08 or FY 09 with minimal state support. In addition, the state will be completing their five year needs assessment process which will help identify priorities. These activities are infrastructure-building services.

Parent navigator services have been well received by families with CSHCN and the demand for this service is increasing. Title V Block Grant funds will be used to expand the parent navigator role. More in-service training will be available to providers, more training materials will be purchased, a presentation will be made at a pediatric conference, a newsletter will be sent to parents of children with facial clefts twice each year, and parent support services will continue at Cleft Lip and Palate Clinics. Specialty clinics will be held in remote areas of the state where specialty services would not otherwise be available. These are infrastructure building and enabling services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		1.1	2	3	3
Annual Indicator		1.1	1.1	1.1	
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for NPM#6, the 2002 indicator is the national average except for Maine which has its State value noted.

Source: 2001 SLATIS/CSHCN Survey, data analysis 4/03.

Prior to 2004 MCHB Title V Block Grant Submission data was obtained from Alaska MCFH, Special Needs Services Unit. Data now comes from the SLATIS/CSHCN Survey.

Performance Objectives for this indicator have been revised to reflect change in source data, 6/03.

Notes - 2003

Source: 2001 SLAITS/CSHCN Survey

Because only one of the States (Maine) met the NCHS standards for reliability for NPM#6, the 2001 indicator is the national average except for Maine which has its State value noted.

/2004/ Prior to the 2004 MCHB Title V Block Grant submission, data was obtained from the Alaska MCFH, Special Needs Services Unit. Data now comes from SLAITS/CSHCN Survey. Performance Objectives for this indicator have been revised to reflect change in data source.

/2005/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.
/2006/ annual performance objective modified for coming years to be more reflective of any progress in the new program initiated by the Govenor's Council on Disabilities and Special Education to assist teens to transition to adult life.

a. Last Year's Accomplishments

The Youth with Disabilities in Transition Summit took place in October 2004. Over seventy representatives from workforce development, vocational rehabilitation, tribal vocational rehabilitation, education, juvenile justice, independent living centers, health and social services, and service providers came together to discuss and develop a coordinated state plan for students with disabilities transitioning to adult life. (infrastructure building services)

Additionally, the Division of Business Partnerships contracted for service providers to pilot an intermediary program. The intermediaries will have a holistic approach to transition. They are to blend and braid resources and funding streams to provide needed transition services. While the intermediary pilot programs are infrastructure development projects, they also have a requirement to serve 200 youth with disabilities in transition (30% of which will be youth with significant disabilities). There are four intermediaries across Alaska -- Anchorage, Fairbanks, Southeast, and the Kenai Peninsula. (infrastructure building services, enabling services)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Share with partners the draft state plan for students with disabilities transitioning to adult life.				X
2. Train intermediaries and partners on benefits counseling, case management, sustainability and evaluation criteria.				X
3. Look for opportunities for the early intervention services staff and the TitleV/CSHCN Director to collaborate with the Governor’s Council on Disabilities.				X
4. Participate in Part C Continuous Improvement Monitoring Process with secondary transition focus.				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In June there will be a conference to share the draft state plan with partners. After the conference the state plan will be "shopped" for support during the upcoming months. The plan highlights and reinforces the importance of the seven guiding principles for transition. The seven guiding principles are academic achievement, career preparation and career exploration, exposure to the world of work, development of social and leadership skills, strong connections with caring adults, access to safe places to interact with their peers, and support services to allow them to become independent adults (including health education). (infrastructure building services)

The intermediaries and partnering agencies will be given training on benefits counseling, case management, sustainability, and the evaluation criteria. After the training session, the intermediaries will begin enrolling both in-school and out-of-school youth. The intermediaries will use and continue to develop partnerships with other agencies (including state agencies, local governments, and service providers) to meet the transition needs of these youth. (infrastructure building services)

c. Plan for the Coming Year

During the upcoming year we will continue to solicit support and to have partners agree to take part in the policy plan surrounding transition services for youth with disabilities. The intermediaries will begin serving youth with disabilities in transition. They will continue to build the infrastructure necessary to continue transition services after the contract ends. The intermediaries will continue to grow their list of partnerships to create a web of services. Youth with disabilities will begin to have opportunities to explore the many options available to transitioning students. University of Alaska's Center for Human Development will evaluate the intermediaries and the state plan. (infrastructure building services, enabling services)

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	83	85	87	89	91
Annual Indicator	70.6	71.2	75.3	79.7	
Numerator					

Denominator					
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85.5	86	86.5	87

Notes - 2002

Source: CDC National Immunization Survey

The most recent NIS data for this indicator is 2001.

Notes - 2003

Source: CDC National Immunization Survey

The most recent NIS data for this indicator is 2002.
/2006 BG note/ Annual performance measure decreased to 85 with only slight increases entered to reflect the challenges and work in progress regarding immunizations in our state. The anticipated implementation of an immunization registry in FY07 or later may assist in better tracking of immunizations and decrease duplicative administraton of immunizations.

Notes - 2004

Source: National Immunization Survey

The most recent data available for this performance measure is 2003. NIS data for 2004 will be available for the 2007 BG submission.

a. Last Year's Accomplishments

National Immunization Survey compiles data for 4:3:1:3:3 which includes polio. That is 4 DTaP, 3 polio, 1 MMR, 3 Hib and 3 Hep B. For 2002 the National Immunization Survey (NIS) data indicated that 75.3% of Alaska children 19 to 35 months of age were current with their 4:3:1:3:3 immunizations. The Alaska NIS data for 2003 shows an increase in this immunization rate to 79.7%. These are infrastructure building services.

During FY 2004, Alaska Women, Infant and Child Nutrition (WIC) staff screened immunization records of children who participate in the program for age--appropriate DTaP (diphtheria, tetanus, acellular pertussis) immunization. If a child was found to be behind in the recommended immunization schedule, a referral to an immunization clinic or health care provider was made. In Anchorage, Alaska's largest city, the Anchorage Immunization Partnership resumed regular meetings with the goal of reviving the community wide effort to improve childhood and adult immunization coverage. Among other projects, the Partnership printed and distributed posters showing community locations where childhood immunizations could be accessed. The Vaccinate Juneau's Kids Coalition conducted "Super Shot Saturday" in August 2004, providing free childhood immunizations in collaboration with local Juneau health care providers. These are infrastructure building, population-based, enabling, and direct health care services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Collaborate with the program for Women, Infant and Child Nutrition (WIC) regarding a review of immunization records for a key immunization indicator (DTAP).				X
2. Offer technical assistance to the immunization coordinator on the ongoing coordination of the Anchorage Immunization Partnership.	X			
3. Revise the Healthy Mom/Healthy Baby Diary to reflect the new immunization schedule and the recommended use of Pediarix (trivalent vaccine).				X
4. Assist Healthy Families home visitation in validating vaccinations and reaching the goal of full immunization by age two.			X	
5. Work with the Section of Epi program on developing a strategy to request funding from the Legislature for immunizations in response to the decrease in federal funding through the Vaccine's for Children program.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY 2005 - The Women, Infant and Children Nutrition program continues to screen immunization records for DTaP immunization status and refer a child for vaccination when his/her record is found to be incomplete. With Funding from the Alaska Nurses Foundation, Alaska's statewide immunization coalition, Vaccinate Alaska Coalition (VAC), is continuing the award-winning "I Did It By TWO!" childhood immunization awareness program. This year VAC produced and aired a TV PSA featuring celebrity dog musher Martin Buser promoting the importance of timely childhood immunization. These are infrastructure building and population-based services.

c. Plan for the Coming Year

The Alaska Immunization Program will provide immunization information and training to Alaska childcare resource and referral agencies, Alaska public health and school nurses, and local immunization coalitions. In addition, the program will provide immunization training for WIC staff upon request. These are infrastructure building services.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23	23	21	21	19
Annual Indicator	24.3	19.1	19.7	19.9	
Numerator	381	301	318	320	

Denominator	15695	15782	16149	16060	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19	19	19	19	19

Notes - 2002

Source: Alaska Bureau of Vital Statistics reported by calendar year.

CY 2002 data is not available at time of 2004 block grant submission. CY 2001 data is the most recent data available. 1995-98 data was updated in 2001 to exclude unknowns from denominators.

Notes - 2003

Source: Alaska Bureau of Vital Statistics reported by calendar year.

Notes - 2004

Source: Alaska Bureau of Vital Statistics.

CY2003 is the most recent data available for this performance measure. CY2004 will be available for the 2007 BG submission.

a. Last Year's Accomplishments

The trend of a decreased birth rate for teenagers age 15-17 between FY00 and FY01 further dropped from 24.3 births to 19.1. There was a slight increase in FY02 to 19.7 and then a slight increase again in FY03 to 19.9; however Alaska has managed to meet its target of less than 23 births per 1000 for three fiscal years. Births where maternal age is unknown have been excluded from the denominator for this year and all previous years.

In addition, family planning services were provided to teens at Family Planning Clinics statewide (direct health care service). Services include abstinence education and support parental involvement in contraceptive decision making. Although the Adolescent program no longer exists, the former Adolescent Health Coordinator continues to promote the Youth Developmental Assets framework to address adolescent risk behaviors through her Youth Resiliency work in the Division of Behavioral Health (infrastructure building and population-based services). The Assets framework has been implemented in most schools statewide and the AK Association of School Boards is a strong partner in the implementation of the Assets framework.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Write an MCH Fact Sheet on Alaska’s teen pregnancies and sexual behaviors among Alaskan high school students.				**X**
2. Distribute MCH Fact Sheet to legislators as part of an educational effort regarding work that is done in public health.				**X**
3. Create a dynamic data web page that makes data related to this indicator easily accessible and available on the MCH Epi website.				**X**

4. Continue family planning with a focus on teens at statewide family planning clinics.		X	X	
5. Pay for family planning services including education, and pay for contraceptives.	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This year, the Section of Women's, Children's and Family Health (WCFH) was re-established and began to programmatically report to the director of public health in anticipation of its move back to the Division of Public Health (DPH) in SFY06 from the Division of Health Care Services (DHCS).

As part of the Title V 5 year needs assessment, a fact sheet was created regarding Teen Pregnancy and Sexual Behavior in Alaska among Alaskan high school students. This fact sheet along with 40 others is available on the MCH Epi web site and will be updated on an annual basis. It was distributed to legislators during this past session as part of an educational effort regarding the work that is done in public health. In addition, the MCH Epidemiology Unit created a dynamic data web page that makes data related to this indicator easily accessible and available on the MCH Epi website. These are infrastructure-building services.

Family planning with a focus on teens has continued at the statewide Family Planning clinics and abstinence remains one of the topics covered in their educational curriculum.

c. Plan for the Coming Year

In FY06, the newly reconstituted Section of Women's, Children's and Family Health (WCFH) will administer the federal abstinence grant which provided local school districts with funding to conduct the Postponing Sexual Involvement training to junior high and high school students (population-based services). This activity was transferred back to the new section in the Division of Public Health midway through the year from the Office of Children's Services. It is anticipated additional teen pregnancy prevention activities will take place in the new fiscal year in coordination with the Title X Family Planning Conference.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	22	18	20	22	24
Annual Indicator	15.4	15.7	15.7	14.9	14.4

Numerator	3306	3311	3295	3127	2966
Denominator	21418	21105	20988	20988	20598
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	26	26	26	26	26

Notes - 2002

Source: Alaska Division of Medical Assistance & Department of Labor

Calulated using FFY 01 and FFY 02 incident Medicaid sealants applied to permanent molars of 8 and 9 year olds. This percentage is applied to approximated July 1, 2000 8 and 9 year-old population for 2001 and the July 1, 2001 8 and 9 year population for 2002. Denominators were obtained using 40% of 5-9 year-old Alaska Department of Labor population estimates.

FY 1999 data was updated using revised information from Medicaid services.

Notes - 2003

Source: Prior to 2005 BG: Alaska Division of Medical Assistance & Department of Labor. Data source has changed to MCH Epidemiology Unit, Dale Williams for the 2005 BG application.

/2004/ Calulated using FFY 01 and FFY 02 incident Medicaid sealants applied to permanent molars of 8 and 9 year olds. This percentage is applied to approximated July 1, 2000 8 and 9 year-old population for 2001 and the July 1, 2001 8 and 9 year population for 2002. Denominators were obtained using 40% of 5-9 year-old Alaska Department of Labor population estimates. FY 1999 data was updated using revised information from Medicaid services.

/2005/ Reporting years 2000-2002 have been modified. The new figures reflect the following changes: 1) We are now reporting state fiscal year rather than federal fiscal year. 2) The methodology that was used in previous years was revised using total number of 8-9 year olds receiving protective sealants on at least one permanent molar tooth in the Medicaid database during the state fiscal year, rather than the number receiving this service by mid-year.

SFY 2003 is provisional. The 2003 population denominator was not available in time for the 2005 BG submission, so 2002 was used as an estimate. This figure will be updated for the 2006 BG.

Notes - 2004

//BG2006// 1,166 unique children between 8 and 9 years old with dates of service between 7/1/2003 and 6/30/2004 who had sealant applied to permanent molars (teeth 1-3, 14-19, or 30-32). The denominator is 8,122 for Medicaid eligibles. AKDOL population estimates used to obtain the 14.4% of estimated 8 and 9 year olds in Alaska with sealant applied to at least one permant molar.
//BG2006//. New open mouth survey conducted in FY05 indicated a signifcant increase in the percentage of children with dental sealants than what our proxy measure had indicated. Thus the annual performance objective will stay the same /2006/.

a. Last Year's Accomplishments

Data were collected which reflect the number of unduplicated Alaska children aged 8-9 years with dental sealant(s) applied to permanent molar(s) paid for by Medicaid. Sealants not billed to Medicaid were excluded; therefore actual sealant utilization was underestimated. (infrastructure

building)

Percentage of children with at least one dental sealant applied and billed to Medicaid for FY1997-2004 is as follows: 23 (1997), 18 (1998), 15, (1999), 15.9 (2000), 17.2 (2001), 16.6 (2002), 15.5 (2003) and 16.3 (2004).

In SFY2004, with funding from U.S. Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration, the Oral Health Program (OHP) conducted the first statewide dental assessment using the "Basic Screening Survey" developed by the Association of State and Territorial Dental Directors. It found overall sealant utilization in children at 52.5%, meeting the dental sealant objective for Healthy People 2010. Sealant utilization was higher in American Indian/Alaska Native children; possible needs were identified for improving sealant utilization in other minority groups and for white children enrolled in the Medicaid/Denali KidCare Program. The surveillance project highlights the extent to which Medicaid claims data underestimated sealant utilization for the general population. The dental assessment project is being expanded to include kindergarten-age children and children enrolled in Head Start in SFY2006 and will be repeated for these three sampling groups in SFY2007. Funding has not been identified to conduct ongoing assessments. See attachment for assessment results. (infrastructure building)

Other accomplishments include transitioning the grant between Division of Health Care Services, OHP and Southeast Alaska Regional Health Consortium into an EPSDT/Medicaid continuing care agreement. This grant funded travel for pediatric dental teams to serve children enrolled in Medicaid/SCHIP in Southeast Alaska. Continuing care agreements often increased funding sustainability for the project and have since been expanded to Norton Sound Health Corporation (Nome region) and Yukon-Kuskokwim Health Corporation (Southwest Alaska). The contract to provide pediatric dental services for the Kenai/Soldotna area was continued providing 1,259 patient visits in FY2003 and projected to provide about that same number in FY2004. (infrastructure building, population-based, enabling, direct health care)

OHP receives funding for building infrastructure through an agreement with CDC Chronic Disease Program. Funds supported staffing for OHP, implementation of a water fluoridation monitoring system in collaboration with Alaska Department of Environmental Conservation, Drinking Water Program and Alaska Native Tribal Health Consortium, convening an oral health work group and planned support for school-based/linked dental sealant programs in schools serving high percentages of children from low income families. (infrastructure building)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect dental access data through Medicaid, PRAMS, BRFSS, YRBS and Basic Screening Survey (BSS) surveys.				X
2. Support and promote community water fluoridation in all communities of Alaska.				X
3. Identify funding to support a statewide dental sealant coordinator.			X	
4. Collaborate with 330 funded Community Health Centers to establish a dental sealant program.			X	
5. Establish an oral health coalition to build a support base for the oral health program and oral health issues.				X
6. Support coalition activities and the development of a state oral health				X

plan.				
7. Conduct and analyze a Basic Screening Survey of third grade and preschool children for statewide data.				X
8. Collaborate with Tribal programs including Head Start and Environmental Health to support dental access, education, sealant application and water fluoridation.				X
9. Maintain program web site for dental access, oral health information and coalition activity.				X
10. Support development of tribal community dental aide/practitioner program.				X

b. Current Activities

In state fiscal year 2005, the Oral Health Program completed the dental assessment of third-grade children (discussed above); updated the "Head Start Dental Action Plan" in conjunction with the Head Start State Collaboration Office and grantee programs; was successful in the addition of dental access/need questions to the state's Pregnancy Risk Assessment Monitoring System (PRAMS); and continued activities related to development of water fluoridation monitoring and a state fluoridation program. The program is currently planning meetings to develop a formal "Memorandum of Agreement" between the agencies involved with drinking water programs and related fluoridation activities. Oral health program staff participated in several fluoridation trainings for water operator and rural maintenance workers to provide background on the role of fluoride in reducing dental decay. These are infrastructure building and population-based services.

The program has developed a contract to develop an inventory of schools and existing dental sealant programs for use in future activities related to promotion and implementation of school-based/linked dental sealant programs. This is an infrastructure building activity.

The Oral Health Work Group has remained active and recently completed action plans related to prevention/education efforts, provider training on oral health issues, and dental access activities. The fluoridation work group met twice per quarter in FY2005 to move fluoridation issues forward. The group assisted in the distribution of community fluoridation awards, development of a legislative fluoride resolution and inclusion of fluoridation in prioritization of funding for water system related capital projects in the Village Safe Water Program. The fluoridation equipment inventory project developed in FY2004 was presented to CDC as CDC plans to utilize such projects in assessment of equipment needs in other states funded under the CDC cooperative agreements. These are infrastructure building activities.

c. Plan for the Coming Year

In state fiscal year 2006 major activities for the oral health program include completion of dental assessments for kindergarten children and children enrolled in Head Start, development of an oral disease burden document using information collected from the oral health surveillance system including the dental assessment data, and working with the oral health coalition and other stakeholders to draft a comprehensive state oral health plan. With increased funding from the CDC cooperative agreement, the Oral Health Program hopes to take a more active role in promotion, coordination, data collection and evaluation of school-based/lined dental sealant programs. These are infrastructure building and population-based activities.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6.6	6.4	6.2	6	5.8
Annual Indicator	5.2	4.5	4.4	6.0	
Numerator	24	21	21	27	
Denominator	464856	471082	481145	447364	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.6	5.6	5.6	5.6	5.6

Notes - 2002
Source: Alaska Bureau of Vital Statistics reported by calendar year.

2001 data was updated to better reflect trends in child death by expressing these rates in 3 year averages.

CY 2001 data is most recent data available for 2004 block grant submission.

Notes - 2003
Source: Alaska Bureau of Vital Statistics reported by calendar year.

/2005/ CY2002 is most recent at time of 2005 BG application. Rate is expressed as a three-year moving average (i.e, year 2002 is the period 2000-2002).

Notes - 2004
Source: Alaska Bureau of Vital Statistics

/BG2006/ CY2003 is most recent at time of 2006 BG application. Rate is expressed as a three-year moving average (i.e, year 2003 is the period 2001-2003).

a. Last Year's Accomplishments

The MCH Block Grant funds a position focused on childhood safety and injury prevention. This position is located in the Division of Public Health, Section of Community Health and Emergency Medical Services (CHEMS), Injury Surveillance and Prevention (ISP) Unit.

In FY 2004, the ISP Unit awarded grants to four SAFE KIDS Coalitions and three chapters in Alaska. These mini-grants were used to purchase new and replacement playground equipment meeting Consumer Product Safety specifications, child restraints, educational materials and personal floatation devices (PFDs) and community-supported Kids Don't Float stations. ISP staff taught Child Passenger Safety (CPS) Technical training course in seven communities throughout Alaska. For the first time, ISP staff used the new Safe Native American Passengers (SNAP) training for transporting children. The SNAP training materials are developed as a result of partial funding from HRSA. This training was provided to the Neonatal Intensive Care Unit personnel at Alaska Native Medical Center (ANMC). In addition to the work activities in

Alaska, the ISP staff participated in a workshop presentation on child passenger safety for underserved communities conducted at the national Life Savers Conference in San Diego. These activities are infrastructure building and population-based services.

The activities in FY 2004 were focused on maintaining current infrastructure in light of state budget constraints, which affected our capacity to provide joint intra-departmental prevention services to Alaska communities. For example, two positions within the Section of Public Health Nursing and who were community-based CPS instructors left state service and were not replaced. This left five instructors to conduct CPS activities statewide. To fulfill the state's needs, the program worked with the Alaska Office of Highway Safety (AK OHS) to bring CPS instructors from out of state to fill in the gaps. AK OHS also provided funding to assist Fairbanks Memorial Hospital to sponsor a part-time CPS inspection program for the Fairbanks area and a similar program with the Southeast Alaska Regional Health Corporation (SEARHC) located in Juneau. Training was provided to fire department personnel in Anchorage, Kenai and Soldotna and other rural communities to meet the increased demand for CPS services. We continued to be a central educational resource for CPS instructors and technicians. These activities are infrastructure building services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Child Passenger Safety (CPS) training through community-based agencies.		X		X
2. Co-sponsor CPS training for those who work with CSHCN.				X
3. Co-instruct five CPS Technician classes.				X
4. Develop and distribute educational materials to promote awareness of and solicit support for primary seat belt enforcement legislation.			X	
5. Create a dynamic MCH/Epi data web page that makes data easily accessible and available.				X
6. Expand the delivery of the culturally relevant SNAP course to child care providers in additional locations.		X		
7.				
8.				
9.				
10.				

b. Current Activities

In FY 2005, administrative support and funding for state-based grants to Alaska's SAFE KIDS Coalitions and chapters has been limited. We continue to provide CPS training across the state by building infrastructure through various community-based agencies. These activities are included and updated the State Injury Prevention Plan, and focus on strategic development and implementation of CPS training and services into community-based agency for long-term sustainability. These activities are infrastructure building services.

Education materials were developed and distributed to promote awareness of and solicit support for primary seat belt enforcement legislation. This legislation passed the State Senate this session and presently resides in the State House where it will be considered next session. These are population-based services.

Two additional Alaskan CPS technicians were certified as CPS instructors this fiscal year in Sitka and in Fairbanks. This strengthens the state's infrastructure and promotes local capabilities to provide CPS training. In addition, this fiscal year ISP staff co-instructed five CPS Technician classes in addition to those conducted by regional instructors--two at ANMC; two in the Kenai Peninsula; and one in Juneau or Fairbanks. Ten shorter CPS courses were also conducted. These activities are infrastructure building services.

The ISP Unit will be co-sponsoring a CPS course for those who work with children with special health care needs in June of 2005 This is the only venue for this course in the Pacific Northwest this year. ISP staff will assist Dr. Marilyn Bull, a developmental pediatrician who has expertise in car seat safety for CSHCN in teaching this course. These activities are infrastructure building services.

c. Plan for the Coming Year

In light of changes by National Highway Traffic Safety Administration (NHTSA), CPS certification administration will be done by the National SAFE KIDS Coalition and certification registration and testing will be completed strictly on-line. State staff recognized this new process will be difficult and confusing for many of CPS technicians who lack computer skills. The plan will be to schedule CPS courses throughout the state to update technicians on the new on-line certification/recertification process and changes in general. At present, Kodiak Island and Bethel are scheduled for the re-certification workshop with their CPS check-up event in early FY06. We will also continue to present at early childhood conferences and workshops on childhood passenger safety. We will be offering a diversion program for those caregivers who are cited for child passenger violation by law enforcement officers.

Other injury prevention activities throughout Southcentral Alaska planned for Fy06 include ISP support of Kids Don't Float programs and stations; planning support for Bike Rodeo skills and safety awareness programs; and active co-sponsorship of the Walk to School program. A snowmachine use and safety awareness program for children and parents will be replicated in Fairbanks, Kenai and Mat-Su communities again this year.

In FY 2006, we are planning the following Enabling Support (ES), Infrastructure Building (IB), and Population Based Support (PBS) activities--
• Supplement local instructors to maintain a 1 to 5 student-to-teacher ratio in reflection of NHTSA requirements (ES).
• Expand training to implement additional CPS technicians in communities not previously covered such as Nome and the Aleutians (IB).
• Continue update of the State Injury Prevention Plan (PBS). Due to the retirement of the state's longtime director of Alaska SAFE KIDS coalition, this will present a transitional challenge in injury prevention programming throughout the state.
• Coordinate and target CPS training and injury prevention programs across Alaska (PBS).
• Retain and increase the number of CPS technicians throughout the state (IB) by offering CPS update and technician courses. This will include planning for itinerant instructors using one of the two SAFE KIDS vans to tour Southeast Alaska (PBS).
• Continue to support the use of local fire departments as CPS inspection stations inclusive of training of fire department personnel (ES).
• Present at the EMS symposium and at early childhood conferences (ES).
• Continue to support the Kids Don't Float programs and stations throughout Southcentral Alaska (PBS).
• Provide planning support for Bike Rodeo skills awareness programs conducted in Southcentral Alaska and actively co-sponsor of the Walk to School program (ES).
• Plan to update the Snowmachine Awareness program (ES).
• Assist with the planning and implementation of an ATV course targeted to caregivers and their children (ES).

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	88	88	88	88	88
Annual Indicator	88.8	90.5	90.5	90.5	
Numerator	8055	8128	8111		
Denominator	9076	8983	8959		
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	92	93	94	95	96

Notes - 2002

Source: Alaska Pregnancy Risk Assessment Monitoring System, birth year.

CY 2000 is most recent data available for 2004 block grant submission.

.

Notes - 2003

Source: Alaska Pregnancy Risk Assessment Monitoring System

CY 2002 is most recent data available for 2006 block grant submission. 2003 data will be available for 2007 BG application. The estimate of 90.5% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.
/2006 Block Grant note/: Annual performance Objective increased to reflect the percentage increases experience in the past with this performance measure that those outcomes expected due to the significant efforts at work in the area of breast feeding promotion in hospitals, prenatal care offices and WIC offices./2006/

Notes - 2004

Source: Alaska Pregnancy Risk Assessment Monitoring System

/BG2006/ CY 2002 is most recent data available for 2006 BG submission. 2003 data will be available for 2007 BG application.

a. Last Year's Accomplishments

In 2003, Alaska was first in breastfeeding duration (63.1%) and second in breastfeeding initiation, 85.7%, for all infants in the United States, according to the Ross Mother Survey (RMS). Alaska exceeded the breastfeeding duration at six months Healthy People 2010

indicator, 50.2%. Alaska was awarded a Using Loving Support to Implement Best Practices in Peer Counseling United States Department of Agriculture (USDA), $80,141.00, Food and Nutrition Services (FNS) Grant. USDA FNS Operational Adjustment (OA) Funds were granted, $45,000.00, to offer a Breastfeeding Basics: Using Loving Support WIC Competent Professional Authority (CPA) Training at the University of Alaska Anchorage. These activities are infrastructure building services.

Alaska WIC conducted a State Agency Implementation Plan for Breastfeeding Peer Counseling in collaboration with the Providence Alaska Medical Center (PAMC) WIC Program. State staff began the development and testing of nutrition surveillance reports including Alaska WIC specific breastfeeding initiation and duration rates data. These activities are infrastructure building services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the Alaska WIC Competent Professional Authority (WIC CPA) Phase III Training: Alaska Breastfeeding Basics: Using Loving Support.				X
2. Create fact sheet outlining status of breast feeding in Alaska.			X	
3. Provide counseling, education materials and breast pumps through WIC.		X		X
4. Continue expansion of the Lactation Advisory Groups in other smaller communities in Alaska.			X	
5. Continue data collection and monitoring through PRAMS.				X
6. Continue active participation with the Alaska Breastfeeding Coalition.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Alaska WIC is the recipient of $82,000.00 to continue to implement the Using Loving Support to Implement Best Practices in Peer Counseling Program and $75,000.00 WIC Operational Adjustment (OA) funds to provide the Breastfeeding Basics: Using Loving Support Training through the University of Alaska Anchorage. The goal is to provide information to private employers, WIC participants' extended families, and Community Health Aides, Infant Learning Program, and Head Start staff in support of the Alaska Breastfeeding Plan. This is an infrastructure building activity.

As part of the 5 year needs assessment, a WCFH Fact sheet was created outlining the status of breast feeding in Alaska.

c. Plan for the Coming Year

Expand the Using Loving Support to Implement Best Practices in Peer Counseling Program. Training will be provided in three regions: Bethel, Anchorage and Southeast Alaska. The State Agency will contract with the University of Alaska Anchorage (UAA), via the UAA WIC Competent Professional Authority (CPA) to deliver this training. This is an infrastructure

building activity.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40	45	50	55	60
Annual Indicator	60.3	61.2	65.4	81.1	91.8
Numerator	6014	5744	6430	8081	8968
Denominator	9975	9390	9830	9959	9769
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	92	94	96	98	100

Notes - 2002

Source: Alaska MCFH, Child Health Unit, Calendar Years.

Numerator obtained from seven hopsitals known to be conducting voluntary hearing screenings in CY 2002. Denominator is CY 2002 occurrant births obtained from Alaska Bureau of Vital Statistics.

Notes - 2003

Source: Health Care Services.

/2004/ Numerator obtained from seven hopsitals known to be conducting voluntary hearing screenings in CY 2002. Denominator is CY 2002 occurrant births obtained from Alaska Bureau of Vital Statistics.

Notes - 2004

/2006-block grant note/: the annual performance measure was updated for the coming years to reflect the actual progress being made in this area and to serve as a goal for the hospitals and birthing facilities in the state to acheive collectively even though there is not legislation mandating this program or its reporting//2006//.

a. Last Year's Accomplishments

Site visits were made by the Early Hearing Detection and Intervention (EHDI) Program Manager and the EHDI Surveillance Manager to communities implementing the screening programs to provide technical assistance and connect providers involved in the EHDI process beginning at the screening facility, through the diagnostic phase, and ending at early intervention. Screening is now being performed at all birthing hospitals or communities where a birthing facility exists in the State. In an effort to assist facilities with annual birthing rates of less

than 50 to begin newborn hearing screening, the EHDI Program purchased five portable hearing screeners and placed them in five communities. The program purchased two additional portable screeners for placement in public health nursing (PHN) centers in areas with high home/midwifery center births. Education efforts directed at the direct-entry midwives (paraprofessional midwives) and certified nurse midwives who deliver in free-standing birthing centers showed enthusiasm and willingness to send their clients to PHNs for hearing screening. These are infrastructure building, population-based and enabling services.

The EHDI Program developed a video for rural Alaskan healthcare providers, termed Community Health Aide/Practitioners (CHA/Ps). The video identifies newborn hearing screening, speech and hearing developmental milestones, high risk factors for late onset and/or progressive hearing loss, and proper protocol for CHA/Ps if a hearing loss is suspected in a child. The EHDI Program Manager worked with the CHA/P Program to disseminate the video through teleconference presentations with CHA/Ps, mail outs for continuing medical units, and in-person presentations. Using footage from the video, the EHDI Program developed one radio public service announcement (PSA) and one television PSA. Using the PSAs, the EHDI Program conducted a statewide media campaign focused on rural Alaskans stressing the importance of screening newborns at birth for hearing loss. These are infrastructure building, population-based and enabling services.

As part of the reorganization of the Department of Health and Social Services, the information technology and data support staff was centralized. This resulted in a loss of data base development expertise for a web-based EHDI reporting and surveillance system. Consequently, a decision was made to purchase a commercial product and the process of procurement was initiated in FY04. The goal is to choose a vendor and launch the web-based system by the end of FY05. This service is infrastructure building.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Community Health Aides/Practitioners to distribute educational videos.		X	X	X
2. Travel to communities with implemented UNHS and assure linkages to EI, medical home, and audiology.			X	X
3. Assure full implementation of the internet based data reporting system for newborn hearing screening.				X
4. Complete training for the OZ systems to communities who are served by public health nurses for the newborn hearing screening.				X
5. Provide training on the web based internet system to providers of pediatric audiology services and early intervention services.				X
6. Repeat public media campaign in January-March 2005 in support of introducing legislation for mandating screening, tracking, and reporting.			X	
7. Develop and distribute a 12 month calendar emphasizing messages disseminated through the EHDI media campaign and distribute to all birthing facilities.			X	
8.				
9.				
10.				

b. Current Activities

The EHDI Program developed a 12-month calendar for parents of newborns to re-emphasize messages disseminated during the EHDI media campaign including normal speech and hearing developmental milestones and the importance of newborn hearing screening. The calendars were distributed to all hospitals and birthing facilities for distribution to new mothers during their delivery stay. The EHDI Program Manager and EHDI Surveillance Manager traveled to all communities implementing newborn hearing screening programs not visited in 2004. The EHDI Program Manager will continue to work with hospitals and birthing centers to increase the number of newborns screened. In an effort to reach babies born in birthing centers and delivered at home, the EHDI Program placed an additional portable hearing screener at the public health center in a community south of Anchorage. These are infrastructure building, population-based and enabling services.

In a presentation at the CHA/P Forum in Anchorage conducted in early May, it was apparent that many of the health aides and practitioners were not aware of the education video developed last year for the purpose of educating them about the early hearing detection and intervention program. A second presentation was conducted the following week to the CHAP directors who supervise the community health aids in an effort to impress the importance of following high risk children who return to the rural community, and assure they receive hearing screens every 6 months to age 3. A continued effort will be made to distribute this material to the community health centers and to remind the CHA/P directors to include this video in their educational materials. These are infrastructure building and population-based services.

OZ Systems was awarded a three year contract to provide and support the web based reporting and surveillance system . Four training sessions were conducted in May of 05 with 22 nurse managers/screeners from 15 birthing hospitals traveling to Anchorage for database training. A separate training session was offered for audiologist and early intervention program providers with 6 people representing 6 facilities attending. The OZ trainer also conducted a half-day session for the State Surveillance Manager and the Administrative Clerk who supports the EHDI program. These are infrastructure building services.

c. Plan for the Coming Year

With the purchase of the OZ Systems database, training for facilities that could not send someone to Anchorage will be a major activity. The EHDI Surveillance Manager will travel to those communities to provide hands on training. It is anticipated that all birthing facilities will be online and reporting through this system by fall of 2005. Tracking and follow-up activities will be enhanced with this system in an attempt to meet the National EHDI 1-3-6 goals. The Surveillance Manager will be able to perform monthly QA reports and respond to facilities in a timelier manner regarding follow-up screening and diagnostic procedures. These are infrastructure building services.

Continued educational efforts will ensure that members of the health community are aware of hearing screening, know where to go for screening and diagnostic testing, and know what milestones to watch for in children at risk for progressive/late onset hearing loss. These are infrastructure building services.

The EHDI Program Manager will be working with the Early Head Start Program to provide hearing screening equipment in centers around the State. This is part of the Early Childhood Hearing Outreach (ECHO) project that will reach young children in this program who may experience progressive/late onset hearing loss. These services are infrastructure building and population-based.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	8	8	8	8	8
Annual Indicator	17.3	13.3	12.2	13.1	
Numerator	38000	26830	24740	26710	
Denominator	220000	201060	203540	204240	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	14	14	14	14

Notes - 2002

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 & 2002 Current Population Surveys.

There continues to be no reliable system within the State of Alaska for reporting this measure. Alaska Division of Medical Assistance refers MCFH staff to Kaiser Foundation Survey for 2001 data on uninsured youth. Kaiser data includes children aged 18 years and younger.

1999 data is for FY 1999.
Numerator was changed to reflect all children without health insurance, rather than medicaid only.

1998 data is not available.

Notes - 2003

Source: Kaiser Family Foundation

/2006/ Most recent data available at time of 2006 BG submission is based on 2002-2003 analysis, 2004 data will be available for 2007 BG submission.
/2006 Block grant note/: The annual performance measure updated to reflect the actual experience and as a goal to maintain what is currently being experienced. With the changes to the SCHIP eligibility levels in the SCHIP program, just holding steady at the current numbers of children without health insurance will be a challenge.

Notes - 2004

Source: Kaiser Family Foundation

/2006/ Most recent data available at time of 2006 BG submission is based on 2002-2003 analysis, 2004 data will be available for 2007 BG submission.

a. Last Year's Accomplishments

The Alaska Native Tribal Health Consortium, who received a Robert Wood Johnson Covering Kids and Families grant during FFY 03, continued with the primary responsibility for outreach during FFY 05. The Covering Kids grant supports development of a statewide coalition and two

pilot projects. Its project to modify renewal notice format and envelopes was implemented after a successful pilot test. The program has also provided training sessions statewide and assisted families in completing applications for Medicaid and Denali KidCare, Alaska's Title XIX and XXI programs (infrastructure building).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the Alaska Covering Kids Coalition to asure goals of the Robert Wood Johnson Covering Kids and Families grant are met.				X
2. Continue to work with the Division of Medical Assistance in their outreach efforts.				X
3. Continue support to the toll-free hotline which provides referrals to care.				X
4. Work with the Office of Rural Health on assuring implementation of pediatric standard of care in the federally qualified public health center.			X	X
5. Support Anchorage Access to Care Projects.				X
6. Monitor the numbers of children on the SCHIP program called Denali KidCare (Title XXI) and the number of families on family Medicaid (Title IX).				X
7. Work collaboratively with Medicaid in the review of payment schedules for services provided through the EPSDT program.			X	
8. Work collaboratively with Medicaid in developing regulations around programs for children, for example providing access to O.T., P.T., Audiology, and Speech-Language services to children in the school systems who have an IEP and qualify for services.			X	
9.				
10.				

b. Current Activities

Beginning with the FY 2004 application, the Kaiser Family Foundation is the data source for this measure. This Foundation estimated that 13% of Alaska's children were uninsured in FY 2001 and 12% in FY 2002. When the FY 2004 application was prepared, there was concern that a reduction in the income eligibility level for the Denali KidCare program from 200% to 175% of the federal poverty level beginning in September 2003 would increase the number of uninsured children. The eligibility ceiling since that date has remained frozen at the 2003 Federal Poverty Level for Alaska. Thus the current eligibility ceiling, after adjusting for inflation, is now at the 166% FPL. However a second eligibility tier, 150% FPL for families with health insurance, was not included in the legislatively mandated limit. It continues to be updated annually to adjust for inflationary changes. The department has so far unsuccessfully advocated increasing the Denali KidCare eligibility ceiling.

The number of children covered under Denali KidCare (Title XXI funding) has declined by almost 3.9% between FFY 2003 and 2004, while the number of children insured under Title XIX funding has increased by about 2.1%. The total number in both programs increased by 1.2%. This overall increase may be greater than the increase in population. The Alaska Department of Labor and Workforce Development estimates the number of children 0 to 19 years increased by 0.6% between July 1, 2003 and the same date in 2004.

The department is supporting the work of the Anchorage Access to Health Care Coalition. They are recruiting doctors to donate their time to serve low income uninsured patients who don't have other coverage; March 2005 they have recruited almost 100 physicians towards their goal of 560 in Anchorage by October 2005 (infrastructure building).

c. Plan for the Coming Year

In FFY 06, the State will continue to follow Title XXI State Plan. State outreach efforts will include supporting the Alaska Covering Kids Coalition to ensure that the three goals of the Robert Wood Johnson Covering Kids and Families grant are met. These goals are outreach, program simplification and coordination with other health coverage options or programs. The RWJ grant will end in September 2006 (infrastructure building).

The department will continue to support the Anchorage Access to Health Care Coalition's efforts to recruit physicians to donate services to the uninsured. This will be followed up with projects addressing other coverage gaps such as acquiring donated prescriptive drugs (infrastructure building).

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	77	79	81	83	85
Annual Indicator	82.3	83.8	84.8	84.9	85.5
Numerator	54793	60338	64418	67156	68734
Denominator	66611	71977	76009	79116	80417
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87	89	91	91	91

Notes - 2002

Source: Division of Medical Assistance Annual Report, SFY 2002.

Notes - 2003

Source: Division of Medical Assistance Annual Report, SFY 2002.

/2005/ Data Source: STARS Database

Reporting years 2000-2002 have been modified. The new figures reflect the following changes:

1) We are now reporting federal fiscal year rather than state fiscal year. 2) In the past we were reporting on the 0-19 population, we have changed this to 1 through 20 population.

Notes - 2004

//BG2006// Due to change in state staff, this performance measure was reported for SFY2004 rather than FFY2004 for this BG application.

a. Last Year's Accomplishments

The percent of potentially Medicaid-eligible children who received a Medicaid-funded service was 85.5% during FFY 2004 a 0.6% increase from FFY 2003. This proportion has been increasing steadily since 1997.

The State Department of Health and Social Services continued to work with various Tribal health corporations to help them develop capacity for serving the health needs of their beneficiaries. It has also supported the private sector taking an expanded role. One of the largest Tribal corporations has had a continuing care agreement to enhance their provision of services related to the Early Periodic Screening Diagnosis and Treatment program since 1998 and the department continues to support development of Tribal corporations' ability to provide well child exams. Since federal fiscal year 2003, the Office of Program Review in the AK DHSS Commissioner's Office began efforts to encourage other Tribal corporations to consider entering into similar agreements (infrastructure building).

The staff members who work in the EPSDT program collaborated with staff from the other Medicaid programs to develop a Medicaid benefits booklet that outlined the benefits for all populations served by Medicaid. The booklet was set up similar to those produced for commercial health insurance programs with benefits specific to children ages 0-21 and children with special health care needs highlighted for easy viewing. The booklet was written at a 6th grade reading level and was designed to be accessible and downloadable from the Division of Public Assistance Web site (population-based service).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support as needed the work for more tribal health organizations to enter into continuing care agreements.				X
2. Work with private providers to encourage them to increase the number of well-child exams and enrich the quality of care associated with these exams.				X
3. Send contact letter to pregnant women to inform them of program coverage and eligibility.		X	X	
4. Increase education to foster parents to improve numbers of kids in state custody seen for EPSDT and other Medicaid services.		X	X	
5. Distribute new Medicaid beneficiary booklets to all families/heads of households receiving Medicaid service in Alaska.			X	
6. Continue ongoing outreach efforts in the form of reminder letters and simple educational newsletters.			X	
7. Assist Medicaid beneficiaries with no reading ability or low literacy capacity to find information regarding their benefits.		X		
8. Operate a toll-free Medicaid Recipient Helpline.		X		
9.				

10.					

b. Current Activities

Distribution of the new Medicaid benefits booklet occurred in FY05 with over 55,000 copies distributed to families statewide. A process was developed in collaboration with the Division of Public Assistance to distribute a booklet to each new beneficiary at the time of enrollment. Every effort is made to assist a Medicaid beneficiary to find the information in their benefits booklet whenever questions are called into either the Divisions of Public Assistance, Health Care Services, Public Health or First Health, who is the contracted Medicaid administrator. Consideration is given to those beneficiaries who are without any reading skills or have a low literacy capability. In addition, the operation of a toll free Medicaid Recipient Helpline and the distribution of helpline "business cards" with helpline contact information via phone, fax, email, a web site and mail has been implemented (enabling services).

The EPSDT staff continues to support five additional Tribal corporations that have signed continuing care agreements with the State of Alaska DHSS as they assume greater responsibility for providing services related to the Early Periodic Screening Diagnosis and Treatment program in exchange for increased funding (infrastructure building)

We are initiating two new method of educating foster parents to improve the level of EPSDT and other Medicaid services to children in state custody. As a result, EPSDT outreach contacts to foster parents are doubling. Additional strategies will be implemented as needed (infrastructure building).

c. Plan for the Coming Year

The DHSS Office of Program Review will continue to work with Tribal corporations on the development and implementation of various strategies for increasing their capacity to provide services to their beneficiaries. The greatest impact from these efforts for Medicaid-eligible children will be related to the continuing care agreements (infrastructure building).

In addition, the EPSDT program will continue to support private providers and encourage them to: 1) increase the number of well-child exams they conduct; and 2) enrich the quality of care associated with these exams. The department will continue helpline operation, distribution of handbooks and helpline "business cards." Finally the department will continue to improve education of foster parents on the use of EPSDT as well as other Medicaid services (population-based services).

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1
Annual Indicator	0.8	1.3	0.9	0.9	
Numerator	82	125	91	89	

Denominator	9949	9956	9908	10048	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.5	0.5	0.5	0.4	0.3

Notes - 2002

Source: Alaska Bureau of Vital Statistics, reported by calendar year.

CY 2001 data is most recent data available for 2004 block grant submission.

Notes - 2003

Source: Alaska Bureau of Vital Statistics
/2006 Block Grant Note/: The annual performance measure was updated to reflect the actual outcomes reported and a goal for the future that appears to be realistic based upon the ongoing emphasis in this state on LBW and VLBW.//2006//

Notes - 2004

Source: Alaska Bureau of Vital Statistics

CY 2003 data is most recent data available for 2006 block grant submission. 2004 data will be available for the 2007 BG application.

a. Last Year's Accomplishments

With the dismantling of the Section of Maternal, Child and Family Health, work in this area has focused on collaboration with the March of Dimes on their Prematurity Prevention campaign. The Title V/CSHCN Director sits on the program review, public affairs and campaign steering committees for the March of Dimes. Currently the program services committee for the March of Dimes is evaluating program proposals focused on reducing the number of premature births. Once a decision is reached, efforts to collaborate and support the proposal with some funding, staff expertise and/or technical assistance from the Division of Health Care Services, Children's Screening Services will be considered. These activities are infrastructure-building activities.

In addition, with the changes in eligibility for pregnant women's Medicaid, ongoing monitoring will be important in order to evaluate the numbers of women who seek out prenatal care late in their pregnancy or deliver with no prenatal care due to their ineligibility for Medicaid coverage. In addition, changes in the percent of very low birth weights among all births will be important to track. This is an infrastructure building activity.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with the March of Dimes on their Prematurity Campaign.				**X**
2. Track changes in percent of very low birth weights among all births.				**X**
3. Create dynamic data web page that makes available detailed low birth weight prevalence tables on the MCH Epi website.				**X**
4. Write a fact sheet on low birth weight and preterm births in Alaska.				**X**
5. Provide nutrition education and supplemental foods through state WIC				

program.		X		
6. Collaborate with Tobacco Prevention Program on cessation education and training activities.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Alaska has made significant progress toward achieving the Healthy People 2010 (HP2010) goals. LBW and VLBW among singleton births achieved the HP2010 goals in 2003. Nationally, rates of LBW and VLBW were 1.8 and 2 times higher respectively compared to Alaska. Preliminary national data indicate that Alaska ranked number one for LBW.

The MCH Epidemiology Unit created a dynamic data web page that makes available detailed low birth weight prevalence tables on the MCH Epi website. In addition a fact sheet entitled: "Low Birth Weight and Preterm Births in Alaska" was created as one of 40 fact sheets for the Title V 5-year needs assessment. These are infrastructure-building services.

WIC continues to place emphasis on outreach and collaboration with referral agencies/entities in the state and community levels in an effort to address the problem of low birthweight in Alaska. Nutrition education information and referral to prenatal care services are provided to help ensure positive birth outcomes and reduce the incidence of low birth weight among infants born to women who were enrolled in the WIC Program during their pregnancy. These activities are enabling services.

c. Plan for the Coming Year

The Title V/CSHCN director along with staff from the Division of Public Health, Section of Women's, Children's and Family Health, will continue to participate in the community efforts with statewide obstetrical health care providers, professional medical and nursing organizations, and the local March of Dimes chapter focused on reducing the percentage of low birth weight newborns. Ongoing collaboration with WIC will also occur as they anticipate serving more than 24,000 pregnant women in FY06.

In addition, the Title V/CSHCN director is collaborating with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) local section in a state-wide dual location conference that will focus on preterm delivery, prevention and education efforts as well as early assessment for preterm labor. A nationally recognized speaker, Dr. John Elliott, will be one of the featured speakers. The conference will be held in both Anchorage and Fairbanks on the same weekend at the end of September. The dual locations will enable more nurses to attend in a location closer to them. This is an infrastructure building activity.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	31.2	29.2	27.2	25.2	23.2
Annual Indicator	40.3	37.9	34.9	31.0	
Numerator	59	57	54	49	
Denominator	146500	150469	154674	158041	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	28	26	24	22

Notes - 2002

Source: Alaska Bureau of Vital Statistics, reported by calendar year expressed in 3 year averages.

Data updated in 2001 to reflect 3 year averages.

Notes - 2003

Source: Alaska Bureau of Vital Statistics

Rate is expressed as a three year average (i.e., 2003 is comprised of 2001-2003).
/2006 Block grant note/: Annual performance measure updated to reflect the trend in decrease with the three year moving average //2006//.

Notes - 2004

Source: Alaska Bureau of Vital Statistics

2003 data is the most recent data available for 2006 block grant submission. 2004 data will be available for the 2007 BG application.

a. Last Year's Accomplishments

The Division of Mental Health and the Division of Alcohol and Drug Abuse were reorganized into the Division of Behavioral Health in FY2004. A considerable amount of time was devoted to planning and integrating the functions of each Division into the new one. The former Adolescent Health Coordinator was hired as the Resiliency Youth Development Specialist to provide assistance to the Division and its grantees as they integrate concepts of resiliency into their services. The Division of Behavioral Health continued with funding to rural communities to prevent suicide and increase wellness. Ongoing staff training was provided and regional suicide prevention wellness conferences were held. These activities were infrastructure building services.

The MCH Epidemiology Unit published teen suicide data in the first edition of the Alaska MCH Data Book. The MCH Epidemiology Unit published and made available on the MCH EPI website an Alaska MCH Fact Sheet that addressed this measure: "Risk Behaviors Among Alaskan Youth Decrease" Vol. 3, No. 4, May 2004. These activities are infrastructure-building services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Publish Alaska MCH Fact Sheets that address teen suicide trends and suicidal thoughts.				X
2. Make available on the MCH Epidemiology website an Alaska MCH Fact Sheet that addresses this measure.				X
3. Support revision of the Service Recreation Plan and the work of the newly named Resiliency Youth Development Specialist.				X
4. Support community teaching on suicide prevention as able.				X
5. Hold regional suicide prevention/wellness conferences.				X
6. Support the release of the Suicide Prevention Council statewide prevention plan and media campaign.				X
7. Support the establishment of a suicide support and advisory council.				X
8. Contract for the suicide follow-up study.				X
9.				
10.				

b. Current Activities

The Division of Behavioral Health continued with funding to rural communities to prevent suicide and increase wellness. Ongoing staff training was provided and regional suicide prevention wellness conferences were held (infrastructure building) The Suicide Prevention Council had a very active year, it released its state Suicide Prevention Plan in September 2004, a media campaign was launched, a suicide survivor advisory committee was established, and the annual report to the legislature was submitted in April 2005 (population-based) The suicide crisis line (population based) is in place, the new "Gate-keeper" training was developed and is being implemented for targeted groups and the contract for the suicide follow-back study was awarded with an anticipated end date of June 2005 (infrastructure building services).

In co-ordination with the WCFH five-year Needs Assessment for the MCH Block grant, the MCH Epidemiology Unit produced several fact sheets on various issues affecting adolescents and teenagers. Suicide was addressed in a special series Fact Sheet that covered child and youth mortality. This Fact Sheet was made available to key representatives from partnering agencies and on the MCH Epidemiology website. These activities are all infrastructure-building services.

c. Plan for the Coming Year

The Division of Behavioral Health will continue with its efforts to integrate the services of the previous divisions. Funding will be continued in rural communities to prevent suicide and increase wellness. Ongoing staff training, regional suicide prevention wellness conferences and "Gate-keeper" trainings are planned and the suicide crisis line will continue. The psychological follow-back autopsies report will be published.
The legislature will decide to sunset the Suicide Prevention Council in June 2005 or extend its tenure to 2009. If it continues, its activities will include:
1) Starting a SPAN Suicide Prevention Awareness network, Alaska affiliate to the national SPAN association
2) Implementing the media campaign by producing radio and televisions scripts, and airing them on radio and television.
3) Establishing a Youth Advisory Committee to the Council
4) Continuing work with the Division of Behavioral Health and other partners in funding,

training, and evaluation activities.
The activities listed above are population-based and infrastructure building services.

The MCH Epidemiology Unit will publish an Alaska MCH Fact Sheet that addresses teen suicide trends and suicidal thoughts. The MCH Epidemiology Unit will complete analysis of YRBS survey data on the association between connectedness variables and suicidal thoughts. These activities are infrastructure-building services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	65	65	65	65	65
Annual Indicator	67.1	71.2	71.4	75.3	
Numerator	55	89	65	67	
Denominator	82	125	91	89	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	80	82	84	86

Notes - 2002
Source: Alaska Bureau of Vital Statistics, reported by calendar year.

CY 2001 is most recent data available for 2004 block grant submission.

Unknowns removed from denomentaor in 2001.

Notes - 2003
/2006 Block grant note/: Annual performance measure updated to reflect the actual performance outcome to date and recognize the stated progress being made in this arena //2006//.

Notes - 2004
Source: Alaska Bureau of Vital Statistics

/2006/ CY 2003 is most recent data available for 2006 block grant submission. 2004 data will be available for the 2007 BG application.

a. Last Year's Accomplishments

Data for FY03 shows a greater increase again in the percentage of low birth weight infants delivered at facilities for high-risk deliveries and neonates (from 71.4 to 75.3). This percentage

exceeds the national performance target of 65% and represents a steady increase since 2000.

Significant challenges exist in transporting women in labor with high risk and/or low birth weight infants from rural or smaller urban communities to Anchorage where the state's only high risk Perinatal unit and Level III nursery are located. This issue has necessitated focused efforts in recent years to improve early identification of high-risk mothers and transfer of them to tertiary care for ongoing care and monitoring. The recruitment of a perinatologist for the native health system, which increased the state's total number of perinatologists to three, has most likely accounted for some improvement again in the numbers of transports into the state's only Level III regional perinatal and neonatal center located at Providence Alaska Medical Center. This has led to an overall increase in access to high risk obstetric care for native women in particular and allows for the possibility of earlier transfer from rural providers to the perinatologist now located at the tribal health facility in Anchorage when potential obstetric problems have been identified. The activities fall into the infrastructure-building level of the pyramid.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the sub-specialty identification and recruitment committee for additional perinatology of the All Alaska Pediatric partnership.				X
2. Work with March of Dimes program services committee to implement project focusing on strategies to reduce number of preterm births.				X
3. Develop a dynamic data web page that makes detailed information on low birth weight deliveries available on the MCH Epi website.				X
4. Collect data from Medicaid claims, the local neonatologist practice and Bureau of Vital Statistics to determine which areas of the state have low birth weight and very low birth weight deliveries.				X
5. Participate in preterm delivery prevention education for nurses throughout the state who care for pregnant women in collaboration with the Association of Women’s Health, Obstetric, and Neonatal Nursing (AWHONN) and the March of Dimes-Alaska Chapter.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Ongoing recruitment by the Alaska Native Tribal Health consortium and the Third Medical Group located at Elmendorf Air Force Base will result in a fourth perinatologist available for statewide consultation. This may also result in a decrease in the high number of pregnant women flown by the Department of Defense to Madigan Air Force Base in Seattle for care and eventual delivery, if pre-term. This is an infrastructure-building activity.

State staff continued to participate in the sub specialty identification and recruitment committee of the All Alaska Pediatric Partnership. The Division of Health Care Services provided Medicaid claims data as part of this assessment phase to determine what births were occurring where. This information combined with data from the local neonatologist practice and the Bureau of

Vital Statistics, once collected will assist in targeting areas of the state that have low birth weight and very low birth weight deliveries. The Title V/CSHCN director is also serving on the March of Dimes program services committee. The committee is currently evaluating proposals that identify programs or educational efforts that will work towards further reducing preterm deliveries as well as assuring mothers with a low birth weight pregnancy, deliver in a high-risk perinatal center. These are examples of infrastructure-building activities.

c. Plan for the Coming Year

The Title V/CSHCN director will continue to work closely with the program services committee of the March of Dimes in the implementation of the project chosen to support that focuses on strategies to reduce the number of premature births. The Division of Public Health, the MCH Epidemiology Unit and the Bureau of Vital Statistics will work on the analysis of data to provide a more targeted approach to earlier identification, transfer and treatment for women at risk for a preterm/low birth weight baby. This is an infrastructure building activity.

In addition, the Title V/CSHCN director is collaborating with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) local section in a state-wide dual location conference that will focus on preterm delivery, prevention and education efforts as well as early assessment for preterm labor. A nationally recognized speaker, Dr. John Elliott, will be one of the featured speakers. The conference will be held in both Anchorage and Fairbanks on the same weekend at the end of September 2005. The dual locations will enable more nurses to attend in a location closer to them. As part of this program the nationally recognized STABLE program focused on early identification of preterm labor, labor management, stabilization and transport will be offered at both Anchorage and Fairbanks as a day-long post conference offering. This is an infrastructure building activity.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	85	85	85
Annual Indicator	80.6	80.9	80.5	80.1	
Numerator	7797	7793	7652	7693	
Denominator	9679	9637	9509	9602	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	85	85	85

Notes - 2002

Source: Alaska Bureau of Vital Statistics, reported by calendar year.

CY 2001 is the most recent data available for 2004 block grant submission.

Women with missing prenatal care information have been excluded from the denominator.

Notes - 2003

Source: Alaska Bureau of Vital Statistics

Women with missing prenatal care information have been excluded from the denominator.

Notes - 2004

/2006/ Source: Alaska Bureau of Vital Statistics

CY 2003 is the most recent data available for 2006 block grant submission. 2004 data will be available for the 2007 BG application.

a. Last Year's Accomplishments

Data collected by the Title XXI coordinator has not yet been analyzed to examine the overall impact to pregnant women as a result of the lower eligibility guidelines. The numbers of women and children qualifying for Title XXI have decreased while the numbers of families qualifying for Title XIX Medicaid have increased. Trending will continue for this fiscal year to measure the impact. These are infrastructure-building services

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Publish trend data, regional data and detailed maternal characteristics related to prenatal care in the second edition of the Alaska MCH Data Book – featuring PRAMS data.				X
2. Create a dynamic data web page that makes available prenatal care data on the MCH Epi website.				X
3. Work with the March of Dimes program services committee to support the implementation of a project of program focusing on preterm delivery prevention, which includes early prenatal care.				X
4. Initiate edits for the Healthy Mom/Healthy Baby diary in preparation for a re-publication. Distribute books throughout Alaska in prenatal offices, public health nursing centers and tribal health facilities.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester decreased slightly in 2003 to 80.1% from 80.5% in 2002. Alaska has not made progress toward achieving the Healthy People 2010 (HP2010) goals for early or adequate prenatal care -- both of these measures remain well below the 90% targets.

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics related to prenatal care in the second edition of the Alaska MCH Data Book - featuring PRAMS data. This will be published in the fall of 2005. The MCH Epidemiology Unit created a dynamic data web page that makes available prenatal care data on the MCH Epi website. The topic of "Prenatal Care" was written up as one of the 40 fact sheets created as part of the MCH 5 year needs assessment process and was a focus of lively discussion during the focus groups that included many community and health care providers.

Edits for the Healthy Mom/Healthy Baby Diary were initiated in 2005 and will be completed by the end of the summer in preparation to re-publish the diaries. These workbooks are very popular and used throughout the state. They contain a variety of prenatal and newborn care topics and represent the primary source of comprehensive information of services and issues (population-based services).

c. Plan for the Coming Year

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), plans to analyze the predictive value of birth certificate information to assess prenatal care. The MCH Epidemiology Unit, MCH Indicator Surveillance Project, plans to publish an Alaska MCH Fact Sheet on trends in prenatal care by race.

In addition, the Title V/CSHCN director is collaborating with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) local section in a state-wide dual location conference that will focus on preterm delivery, prevention and education efforts as well as early assessment for preterm labor. A nationally recognized speaker, Dr. John Elliott, will be one of the featured speakers. The conference will be held in both Anchorage and Fairbanks on the same weekend at the end of September. The dual locations will enable more nurses to attend in a location closer to them. This is an infrastructure building service.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percentage of Unintended Births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	39	38	37	36	35
Annual Indicator	43.2	45.4	45.3	45.3	45.3
Numerator	4153	4314	4248		
Denominator	9608	9493	9385		
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	35	35	35	35	35

Notes - 2002

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

Notes - 2003

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2003 data will be available for 2007 BG application. The estimate of 45.3% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.

Notes - 2004

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2004 data will be available for 2008 BG application. The estimate of 45.3% is provisional and will need to be updated when new data is available - it is the prevalence for 2002. Since the data is provisional and a manual indicator was used, there is no numerator or denominator available.

a. Last Year's Accomplishments

Last year, MCH staff in Women's Health as part of the Division of Health care services partnered with Title X to provide funds for family planning services at two service sites to low income women who were not eligible for Medicaid. In addition, statewide public and provider educational campaigns on emergency contraception continued throughout the year. The family planning program continued to collaborate with the breast and cervical cancer screening program (BCHC) to provide low-cost, seamless family planning services to BCHC clients needing contraception. Finally, MCH staff partnered with other public and community agencies to sponsor the Women's Health Track at the Alaska Public Health Association's annual conference. This conference, as well as several other conferences and training opportunities funded by Title X and the Office on Women's Health, provided updated information for medical providers and public health professionals on women's health issues, including contraception and the need to prevent unintended pregnancies. These are all examples of population-based services.

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics related to unintended pregnancy in the second edition of the Alaska MCH Data Book, featuring PRAMS data. PRAMS also will update the five-year moving average for unintended birth rates by census area with 1997-2001 data for this edition of the Data Book. This will be completed and published in the fall of 2005. The MCH Epidemiology Unit also implemented a dynamic data web page that will make "unintended pregnancy and live births despite use of birth control" data available on the MCH Epi website. These are infrastructure building services.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Publish trend data, regional data, and detailed maternal characteristics related to unintended pregnancy in the education of the Alaska MCH Data Book featuring PRAMS data.				X
2. Update the five-year moving average for unintended birth rates by				

census area with 1997-2001 data.				X
3. Launch a dynamic data web page that will make “unintended pregnancy and live births despite use of birth control” data available on the MCH Epi website.				X
4. Collaborate with public and community-based partners on the Alaska Women’s Health Partnership to educate the public and medical providers about the need to prevent unintended pregnancies in Alaska.				X
5. Use Title V monies to fund three Nurse Practitioner (NP) contracts for family planning services through DHCS.		X		
6. Use Title V funds to contract with a company to analyze pap smears as part of statewide family planning services.		X		
7. Use Title X funds to purchase contraceptives and supplies for PHN sites and to fund 2 delegate family planning sites.		X		
8.				
9.				
10.				

b. Current Activities

This year, the Section of Women's, Children's and Family Health (WCFH) was re-established and began to programmatically report to the director of public health in anticipation of its move back to the Division of Public Health (DPH) in SFY06 from the Division of Health Care Services (DHCS).

Staff in the Women's Health and Family Planning Programs collaborated with public and community-based partners on the Alaska Women's Health Partnership to educate the public and medical providers about the need to prevent unintended pregnancies in Alaska (population-based services). Title V monies currently fund 3 Nurse Practitioner (NP) contracts for family planning services through DHCS; additionally, the Division of Public Health, Section of Nursing receives Title V monies to fund the purchase of a contract to pay for pap smears for all of the family planning sites sponsored by the Section of Nursing (PHN) sites in the state. Title X funds (located in DHCS) are also used to purchase contraceptives and supplies for the PHN sites and to fund two additional family planning clinics in the state. At all Title V and Title X-funded family planning clinics, clinicians help reduce unintended pregnancy in their client population through the promotion of highly effective contraceptive methods including abstinence, and parental involvement in minor clients' family planning decisions. As part of the goals of reducing unintended pregnancy and reducing the morbidity associated with sexually transmitted diseases (STD), Family Planning staff applied for and was awarded $14,000 funds for STD prevention and treatment and $10,000 for contraceptive purchases as directed supplements from Title X Office of Women's Health. These are all examples of enabling services and direct health care services.

DHCS has offered numerous continuing education opportunities throughout the year on all topics related to reducing unintended pregnancy, including sponsorship of the Women's Health Track of the Alaska Public Health Association annual conference (funded with Title X and Office of Women's Health monies). This activity was a population-based service.

Finally, an MCH Fact sheet on the topic of unintended pregnancy was developed as one of the 40 MCH Fact sheets created for the 5 Year needs assessment. The intention was that the information was to also be used for the public as a means to educate them about the issue of unintended pregnancy, be available on the web site and be updated annually. This is an infrastructure building service.

c. Plan for the Coming Year

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), plans to analyze the predictive value of birth certificate information to assess prenatal care. The MCH Epidemiology Unit, MCH Indicator Surveillance Project, plans to publish an Alaska MCH Fact Sheet on trends in prenatal care by race.

Again, Title V dollars will be utilized to fund the contracts for family planning services provided by nurse practitioners and will be re-focused in more needy areas of the state this next fiscal year (direct health care service). Finally, Title X program, WCFH staff formerly located in the Division of Health care services plans to collaborate more closely with Medicaid Services staff on family planning services in an effort to reduce unintended pregnancies in Alaska Medicaid recipients. A proposal to apply for an 1115 family planning waiver through CMS has been developed by the staff in WCFH, approved by both the director of public health and the director of health care services and has now moved to the commissioner's office for final approval. The application process will take approximately a year and will be managed by the nurse consultant in the Family Planning Program of WCFH. During this next year, the position will also work with current Medicaid providers of family planning to expand their services to those women who are eligible currently. These are examples of population-based services.

In addition with the reorganization and re-formation of the Women's, Children's and Family Health Unit and its transition back to Public Health, the abstinence grant awarded by the Administration of Children, Youth and Families will be transferred from the Office of Children's Health to the Division of Public Health. This will enable the administrator of the grant to become reacquainted with teen pregnancy prevention efforts and adolescent health issues although the capacity to focus on adolescents will be very limited. As of this time, there is no position or funding for the Adolescent Health Care position. This activity is an infrastructure building service.

Finally, Family Planning staff has applied for a total of $107, 934 in directed supplements from the Title X-Office of Women's Health for contraceptives, Chlamydia prevention and STD prevention and treatment. If awarded, the monies will be utilized by the public health nursing centers that offer family planning in support of reducing unintended pregnancy, STD prevention and treatment (enabling services).

State Performance Measure 2: *Rate of substantiated reports of harm to children per thousand children age 0 to 18.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17	17	17	17	17
Annual Indicator	19.4	20.8	21.5	21.4	20.5
Numerator	18679	20021	20690	20659	19809
Denominator	964452	963065	964329	966579	965594
Is the Data					

Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17	17	17	17	17

Notes - 2002

Source: Division of Family and Youth Services, reported by state fiscal year expressed in five year averages.

Indicator rate was revised from per hundred in 2003 block grant application to per thousand for 2004 block grant submission.

Substantiated reports of harm are reported as the number of substantiated reports of harm per 1000 children aged 0 to 18 years statewide.

DFYS updated indicator data from 1994-98 to present for 2004 Title V Block Grant application.

Notes - 2003

Source: Division of Family and Youth Services, reported by state fiscal year expressed in five year averages.

Indicator rate was revised from per hundred in 2003 block grant application to per thousand for 2004 block grant submission.

Substantiated reports of harm are reported as the number of substantiated reports of harm per 1000 children aged 0 to 18 years statewide.

DFYS updated indicator data from 1994-98 to present for 2004 Title V Block Grant application.

Notes - 2004

Source: Division of Family and Youth Services, reported by state fiscal year expressed in five year averages.

Rates based on the number of unique children with a substantiated report of harm. Each child counted once regardless of the number of reports substantiated.

a. Last Year's Accomplishments

The State of Alaska has one of the highest rates of child abuse and neglect in the country. The Office of Children's Services (OCS) provides child protection and permanency programs along with programs that provide support to children and families. These programs include: Healthy Families, family nutrition and infant learning. Healthy Families Alaska (HFAK) is a voluntary home visiting program that uses the Family Stress Check List to identify parents who are in most need of support. The program promotes positive parent-child interaction, healthy childhood growth and development and linkage to community resources based on individual strengths and challenges (enabling services).

In FY04 the Johns Hopkins University (JHU) completed their five-year randomized control study. The study findings and organizational changes within the Office of Children's Services resulted in program enhancements to specifically address domestic violence and child abuse and neglect (infrastructure building services).

To address these difficult issues, HFAK programs utilize the services of mental health clinicians to provide clinical supervision, staff training on mental health issues and in some cases, direct service to parents enrolled in HFAK. Staff reports a higher level of confidence in dealing with

families with mental health issues, enhanced collaboration with mental health providers and less resistance from families in seeking mental health treatment.

Supervision is a key element in helping staff stay focused, providing support and guidance to help deal with difficult family issues and to alleviate staff burnout.
Program managers and supervisors attended a three day training on reflective supervision conducted by Kate Whitaker from the Healthy Families America, Western Regional Resource Center. Ms. Whitaker is in charge of training for the state of Arizona and has conducted trainings throughout the United States and Canada.

In FY04, HFAK programs served 427 families. Enrollment has remained stable for the past year. Four of the five HFAK grantee programs are credentialed through Prevent Child Abuse America, Healthy Families America. Two of the four programs have applied for recertification for an additional four years (enabling services).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and implement questionnaire and distribute appropriate educational materials on Shaken Baby Syndrome (SBS) and sudden Infant Death Syndrome (SIDS).			X	X
2. Consult with Healthy Families Alaska programs about their needs and make recommendations to enhance staff training and community collaboration.				X
3. Utilized Title V dollars to fund consultation for assessment and action planning with the Healthy Family programs regarding domestic violence prevention and intervention.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Program modifications focus on the development and implementation of a questionnaire and distribution of appropriate educational materials on Shaken Baby Syndrome (SBS) and Sudden Infant Death Syndrome (SIDS). Materials developed in collaboration with MCHB and other HRSA departments were used in the five programs (population-based services). Materials utilized include "Never Shake a Baby" door cards, pamphlets, videos and posters. Every family visited receives information regarding both issues. A questionnaire regarding Shaken Baby Syndrome addresses a parent's feelings of anger and frustration towards their baby and how they coped with these feelings. The SIDS questionnaire addresses baby's sleeping position; conditions of their sleeping environment such as fluffy blankets, stuffed animals; soft sleep surface, etc.; secondhand smoke and bed sharing. The state's Maternal Child Health Epidemiology unit developed the questionnaire used in this program enhancement and will conduct the program evaluation. Early results are expected by September 2005 (infrastructure building services).

HFAK began an extensive consultative model on domestic violence (DV) with Dr. Linda Chamberlain, Director of the Alaska Family Violence Prevention Project. Each program completed a needs assessment prior to their site visit with Dr. Chamberlain. The assessment covered a broad range of issues including staff training, cultural considerations regarding discussing or screening for DV, program protocols regarding safety in the home, safety for home visitors and agency policy regarding potential DV issues with staff. Programs received feedback from the site visit and recommendations to enhance staff training and community collaboration (infrastructure-building services).

c. Plan for the Coming Year

Prevention of child abuse and neglect is a major focus of OCS. HFAK programs will continue program evaluation around reducing the risks of SBS and SIDS. A screening tool will be developed specifically for the FHAK home visiting programs to address domestic violence. Programs will receive individualized training based on their initial site visit (population-based services).

HFAK anticipates a significant cut in funding which may lead to a decrease in the number of families served. The Kenai Parent Support Program will no longer be staffed through public health nursing. There is strong community support for a Healthy Families home visiting program in this community. A competitive RFP process is underway with an anticipated Healthy Families Kenai program starting to serve families in FY05 with direct service to families by August or September of 2005.

Strengthening and developing new community partnerships and collaboration will be a focus of HFAK in order to better serve families at risk for child abuse and neglect (infrastructure building services).

State Performance Measure 3: *Percentage of Women Who Smoke Prenatally.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	17	16	15	14	13
Annual Indicator	16.8	14.7	17.7	17.7	17.7
Numerator	1603	1370	1677		
Denominator	9533	9341	9465		
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	12	12	12	

Notes - 2002

Data source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

Notes - 2003

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2003 data will be available for 2007 BG application. The estimate of 45.3% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.

Notes - 2004

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2004 data will be available for 2008 BG application. The estimate of 17.7% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.

a. Last Year's Accomplishments

The percentage of women who smoke prenatally was selected as a performance measure because of Alaska's high rate of smoking during pregnancy. In Alaska, according to 2002 PRAMS data, the percentage of women smoking in the third trimester of pregnancy was 17.7% as compared to the Healthy People 2000 goal of 1%. This is a drop of 4% since 1998. Through all of MCFH's activities, but particularly family planning and adolescent health, smoking during pregnancy has been highlighted through awareness materials such as the Healthy Mother/Healthy Baby Diary. The outreach and public education activities directed toward reducing the number of pregnant women who smoke place this performance measure on the population-based services level of the pyramid. PRAMS and WIC will continue to provide data to monitor and track progress. This performance measure is associated with all of the national outcome measures. Additionally, women who smoke during pregnancy are likely to continue smoking after pregnancy putting their infant at increased health risk.

The Children's Health manager participated in a subcommittee of the March of Dimes as part of their program to prevent preterm delivery. MCH staff also provided expertise in the media campaigns designed by the Tobacco Coalition in the state (infrastructure building and population-based services).

PRAMS pretests of the new state-specific questions for Phase 5 data collection resulted in new questions regarding iq'mik use and commercial spit tobacco use during the prenatal period to be added as a modular question on prenatal ETS exposure as a state-specific question on the new Phase 5 PRAMS survey. These data have never been collected before and will be available for birth years 2004-2008 (approximately). (Infrastructure building activities).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Publish trend data, regional data, and detailed maternal characteristics related to prenatal smoking in the second edition of the Alaska MCH Data Book – featuring PRAMS data.				X
2. Create a dynamic data web page that makes updated prenatal smoking data easily accessible and available on the MCH Epi website.				X
3. Republish and distribute Healthy Mom/Healthy Baby Diary.		X		X
4. Provide technical assistance and expertise to Tobacco Coalition on				

media campaign.			X	X
5. Work with local March of Dimes chapter on preterm delivery campaign and targeted focus of developing smoking cessation classes and support systems for pregnant women.			X	
6. Publish a WCFH Fact Sheet on Prenatal Tobacco Use in Alaska as part of the 5 year needs assessment.				X
7. Use WCFH Fact Sheet to educate legislators regarding problems associated with tobacco use among pregnant women and harm done to the fetus and newborn.				X
8. Present analysis on smoking and pregnancy at the annual PRAMS conference.				X
9.				
10.				

b. Current Activities

Current activities include the continuation of those listed from last year as well as the dedication of staff time in working with the local March of Dimes chapters on their preterm delivery campaign with a targeted focus of developing smoking cessation classes with local agencies and hospitals as well as the development of support systems for women who are pregnant. These are population based services.

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics related to prenatal smoking in the second edition of the Alaska MCH Data Book - featuring PRAMS data. This will be published in the fall of 2005. The MCH Epidemiology Unit created a dynamic data web page that makes updated prenatal smoking data easily accessible and available on the MCH Epi website. In addition a WCFH Fact Sheet was produced on Prenatal Tobacco Use in Alaska for the 5 year MCH needs assessment. This fact sheet was widely used during this past legislative session as a means to educate the legislators regarding the problems associated with tobacco use in pregnant women and the harm done to the fetus and newborn. These are infrastructure building activities.

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), also published an Alaska MCH Fact Sheet on "Prenatal Smokeless Tobacco Use in Alaska" and is currently collaborating with CDC personnel on publication "Prenatal Smokeless Tobacco Use among Alaska Native Women in Alaska, 1996-2001". The PRAMS coordinator also presented her analysis on smoking and pregnancy at the annual PRAMS conference. These are infrastructure building activities.

c. Plan for the Coming Year

Staff will be working on data with the Maternal-Infant Mortality Review database to facilitate an analysis looking at protective and risk factors for infants who die of Sudden Infant Death Syndrome. In addition, staff will continue active participation with the March of Dimes and community obstetrical providers to provide information and assistance to women to quit smoking prior to pregnancy. It is anticipated that other publications and analyses by MCH Epi staff will occur during 2005.These are infrastructure building activities.

State Performance Measure 4: *Percentage of Women Who Drink Prenatally.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4	4	4	4	4
Annual Indicator	5.3	5.1	4.3	4.3	
Numerator	509	485	411		
Denominator	9647	9426	9466		
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	4	4	4	4

Notes - 2002

Data source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

Notes - 2003

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

2003 data will be available for 2007 BG application. The estimate of 4.3% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.

Notes - 2004

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2004 data will be available for 2008 BG application.

a. Last Year's Accomplishments

The percentage of women who drink prenatally was selected as a performance measure because of its association with our priority need for reducing preventable birth defects and its FAS surveillance project. Performance Measure #4 is placed on the infrastructure building level of the pyramid because of the program activities directly related to the FAS surveillance project.

Our FAS surveillance program continues to work closely with the office of FAS to provide surveillance data that can be used to enhance FAS prevention programs. Outside of the Department, the data were used by Native health corporations statewide for use in assessment and program planning (infrastructure building). Staff also worked with the Healthy Families programs to address the issue both prenatal as well as postnatal (enabling service). In this intensive home visitation program, it was noted that women will try to not drink during pregnancy and then start up again with heavy drinking patterns after their child is born.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Publish trend data, regional data, and detailed maternal characteristics related to prenatal smoking in the second edition of the Alaska MCH Data Book – featuring PRAMS data.				**X**
2. Create a dynamic data web page that makes updated prenatal drinking data easily accessible and available on the MCH Epi website.				**X**
3. Continue FAS surveillance project in collaboration with MCH Epi and Division of Behavioral Health.				**X**
4. Address issue through Healthy Families Alaska home visiting program.		**X**		
5. Develop a WCFH Fact Sheet on Prenatal Alcohol Use in Alaska as part of the 5 year needs assessment.				**X**
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The proportion of pregnant women who drink alcohol was 4.3% as reported from the 2002 PRAMS data. This is in comparison with the nation at 5.3% and the Healthy People 2010 Goal is < 6%. It should be noted that PRAMS figures and national figures reported are for the last three months of pregnancy. The Healthy People 2010 goals are for the entire pregnancy. The Healthy Alaskan target goal is 3.5%.

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics related to prenatal drinking in the second edition of the Alaska MCH Data Book - featuring PRAMS data. This will be published in the fall of 2005. The MCH Epidemiology Unit created a dynamic data web page that makes updated prenatal drinking data easily accessible and available on the MCH Epi website. In addition, a WCFH Fact Sheet was developed on Prenatal Alcohol Use as part of the 5 year needs assessment. This issue ranked in the top five issues identified by the community focus group for WCFH section to focus us in the coming five years. These are infrastructure building activities.

c. Plan for the Coming Year

Data on prenatal drinking will continue to be used by the FAS Surveillance project as well as the state FAS Coordinator. This data is critical to the FAS Coordinator in continued assessment on the status of prenatal drinking statewide and also in program planning issues. Outside of the Department, the data continues to be requested by Native health corporations statewide for use in assessment and program planning (infrastructure building activities). Staff will continue to work with grantees that deliver the Healthy Families programs to intervene and actively refer women who are drinking especially during their pregnancy, and we will advocate in communities for more treatment facilities for women who have children and need a residential program (enabling service).

State Performance Measure 5: *Percentage of Women Experiencing Physical Abuse by Husbands/Partners Surrounding Prenatal Period*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7	7	7	7	7
Annual Indicator	8.9	8.4	6.0	6	6
Numerator	867	806	572		
Denominator	9709	9555	9508		
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6

Notes - 2002

Data source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

Notes - 2003

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2003 data will be available for 2007 BG application. The estimate of 6.0% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.

Notes - 2004

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2004 data will be available for 2008 BG application. The estimate of 6.0% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.

a. Last Year's Accomplishments

The Alaska Family Violence Prevention Project (AFVPP) training curriculum on childhood exposure to violence was expanded to include new data on the biopsychosocial effects of violence on children. Training resources were distributed, authored/co-authored by the project director, to promote screening in health care settings: toolkit Making the Connection: Domestic Violence and Public Health; and manuals Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health and Identifying and Responding to Domestic Violence: Consensus Recommendations for Women's Health. The Family Violence Prevention Fund (FVPF) distributes them. Training curricula were distributed nationally, at no cost, through the AFVPP website with a link to FVPF (population-based and infrastructure building services).

AFVPP resource library and information office/website were maintained/expanded, to build and update capacity and community-based infrastructure. AFVPP responded to 190 requests for educational/training resources: training manuals and slides, journal/newsletter articles, posters, buttons, magnets, information cards, booklets, books, video/audio public service announcements, project history/background, and an online "Other Links" reference to other resources/websites. AFVPP website activity grew from an average of 2000 recorded views/hits per month in 2000 to over 3000 hits per month in FFY04 (population-based services).

Technical assistance was provided on the National Standards Campaign on Domestic Violence, an initiative involving 15 states working collaboratively to improve healthcare response to domestic violence (population-based services).

AFVPP participated in developing educational films on the impact of domestic violence on children and safety planning, produced by the Alaska Network on Domestic Violence and Sexual Assault. A video on CD-ROM was distributed to domestic violence shelters and programs throughout Alaska (enabling services).

AFVPP provided technical assistance and resources to 19 domestic violence shelters and advocacy programs in Alaska; distributed educational/training resources; participated in distribution of screening tools; assisted a women's shelter in Valdez, AK with a grant proposal on trafficking women; provided training curricula for staff to use in AK communities; and provided research on health effects of violence on victims and children for training, judicial proceedings, and community education (enabling and population-based services).

AFVPP published articles on Alaska EMS providers as witnesses to the hidden indicators of domestic violence on assessment and intervention for children exposed to violence (July 2003, LifeLines); on developing a coordinated response to domestic violence in the public health setting (Health Alert, Volume 9, winter 2004); and on survivors' perspectives on assessing for lifetime exposure to violence (Health Alert, Summer 2004) (infrastructure building services).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Manage, operate and expand the AFVPP resource library and information office/website.				X
2. Respond to requests for technical assistance and training.				X
3. Author a chapter on intimate partner violence for a college textbook.				X
4. Conduct onsite domestic violence needs assessments, onsite visits, and follow-up for the Office of Children’s Services at six Health Families grantee sites.				X
5. Participate in a Healthy Families conference to report recommendations based on #4 above.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The AFVPP continues to manage, operate, and expand the AFVPP resource library and information office/website and respond to requests for technical assistance and training. The AFVPP will respond to an average of 100-200 requests during the year. The AFVPP website remains very active at over 3000 views/hits per month on average. AFVPP staff researches, updates, and expands access to new, "cutting-edge" research/literature on critical intersection between adolescent brain development, exposure to violence, and substance abuse. New resources for health care and domestic violence staff are being identified and distributed, including brochures on identifying domestic violence and domestic violence and its effects on

children (enabling services and population-based services).

The AFVPP project director presented research on the child witness and pediatric survey at a statewide conference on family violence, sponsored by the South Peninsula Hospital, the held in October 2004 in Homer, Alaska. In addition, the AFVPP project director is authoring a chapter on Intimate Partner Violence (IPV) that takes an integrated approach to screening/assessment for domestic violence/intimate partner violence and lifetime abuse and other related health problems and risk behaviors (depression, substance abuse, smoking, etc.) for a new college textbook to be published by Oxford Press. Both of these activities are infrastructure building services.

The AFVPP is conducting onsite domestic violence needs assessments, onsite visits, and follow-up for the Office of Children's Services at six Healthy Families grantee sites in Anchorage, the Mat-Su valley, Fairbanks, Kenai, and Juneau. Technical assistance, training, and resources are being provided. Site recommendations are being drafted and the AFVPP will participate in a Healthy Families conference for final report recommendations in May 2005 (infrastructure building services).

c. Plan for the Coming Year

The AFVPP will continue to develop culturally relevant screening tools, brochures, and other resources for parents and communities, to better understand the effects of domestic violence on children and to address the cognitive, physical, and neurobiological implications of childhood exposure to violence. In addition, follow-up site visits will be conducted with Healthy Families grantees--including but not limited to technical assistance and training--as requested by the Office of Children's Services (infrastructure building services).

The AFVPP will develop an online training curriculum on the health effects of domestic violence on women and children and will plan and conduct a live, national training via videoteleconference on effects of violence on children (requested/sponsored by the Maternal and Child Health Bureau, HRSA) (population and infrastructure building). In addition, the University of Alaska, Distance Education and School of Public Health will collaborate with the AFVPP to develop and deliver an online, distance delivery, training module on violence prevention. (The AFVPP project director was named an Affiliate Assistant Professor at the University of Alaska Anchorage in May 2005.)

Operation, expansion, and improvement of the AFVPP resource library and information office/website will continue, to integrate the latest scientific information and educational resources and incorporate development of online, distance delivery, training curriculum. The AFVPP will continue to respond to requests for technical assistance, training, community outreach (especially for rural communities), and public education; and identify and distribute new resources to health care and domestic violence staff. The AFVPP will continue its collaboration with state, national, and international agencies and organizations. The AFVPP will continue to research, update, and expand the infrastructure and capacity for access to research/literature on biopsychosocial effects of violence on children (population and infrastructure building).

State Performance Measure 6: *Percentage of Mothers Putting Infant Down to Sleep in the Supine Position (On Their Backs)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	65	70	75	80	85
Annual Indicator	64.7	66.7	69.3	69.3	69.3
Numerator	5922	6075	5947		
Denominator	9158	9111	8580		
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	85	85	85

Notes - 2002

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

Notes - 2003

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2003 data will be available for 2007 BG application. The estimate of 69.3% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.

Notes - 2004

Source: Alaska MCFH, MCH Epidemiology Unit, PRAMS, reported by birth year.

CY 2002 is most recent data available for 2006 block grant submission. 2004 data will be available for 2008 BG application. The estimate of 69.3% is provisional and will need to be updated when new data is available - it is the prevalence for 2002.

a. Last Year's Accomplishments

Data for 2002 indicates an increase from 66.7% to 69.3% of mothers who self report in the PRAMS survey they place their infants in a supine position. This indicates that education during prenatal and childbirth classes as well as community education and hospital discharge education has been effective in communicating the message. Hospitals in FY03 reported their efforts to work on educating their African American and Native Alaskan families about the importance of this measure. Education also focused on ways to safely co-bed, avoidance of co-bedding when the caregivers consume alcohol and avoidance of waterbeds and certain types of bedding and pillows. These are examples of population-based services.

The MCH Epidemiology Unit also published prevalence of mothers putting their infants to sleep on their backs in the first edition of the Alaska MCH Data Book 2003.

Also in fiscal year FY03, the revised Healthy Baby and Newborn Diary was updated, printed and distributed to prenatal care providers throughout Alaska. Demand ran so high, that the printing of 15,000 copies lasted only into the first quarter of FY04. The handbook contains much of the same information produced by MCHB, but also has many Alaska specific resources and information more relevant to Alaskan families. Examples of specific information in the book include the Back to Sleep campaign and the issues of co-bedding as well as what types of bedding are appropriate for newborns and infants. Copies are free to the public. This is

an infrastructure-building activity

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Publish trend data, regional data, and detailed maternal characteristics on the prevalence of mothers putting their infants to sleep on their backs in the second edition of the Alaska MCH Data Book - featuring PRAMS data.				X
2. Create a dynamic data web page that makes updated prevalence of infant sleep position data easily accessible and available on the MCH Epi website.				X
3. Update, publish and distribute Healthy Mom/Healthy Baby Diaries which stress the “Back to Sleep” message.			X	
4. Continue to distribute Back to Sleep Campaign materials.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This year, the Section of Women's, Children's and Family Health (WCFH) was re-established and began to programmatically report to the director of public health in anticipation of its move back to the Division of Public Health (DPH) in SFY06 from the Division of Health Care Services (DHCS).

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics on the prevalence of mothers putting their infants to sleep on their backs in the second edition of the Alaska MCH Data Book - featuring PRAMS data. This is expected to be published in the fall of 2005. The MCH Epidemiology Unit created a dynamic data web page that makes updated prevalence of infant sleep position data easily accessible and available on the MCH Epi website. These are infrastructure-building activities.

Materials on the Back to Sleep Campaign continue to be distributed from the Division of Health Care Services. Anecdotal information from the hospitals indicates this is an issue that still receives a lot of attention in their discharge-teaching curriculum. Facilities caring for native families have also developed their own materials targeting co-bedding and alcohol usage. These are examples of infrastructure-building and population-based activities.

c. Plan for the Coming Year

The Title V/CSHCN director plans to work with MCH EPI staff to examine infant death records as part of the Maternal-Infant Mortality Review (MIMR) committee activities to determine if sleeping position has been recorded and continues to be an issue. The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS) plans to link data with the MIMR database to facilitate an analysis looking at protective and risk factors for infants who die of Sudden Infant Death Syndrome. These are examples of infrastructure building activities.

Finally, educational materials distributed state wide will be reviewed and considered for revision depending on the outcome of the data analysis.

State Performance Measure 7: *Percentage of people experience intimate partner violence during their lifetime.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23	23	23	23	23
Annual Indicator		24.0	24	24	23.9
Numerator		104691			101723
Denominator		436215			425826
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	23	23	23	23	23

Notes - 2002

Source: Alaska BRFSS

Data for this indicator was not available in 2002. The estimate provided is provisional - it is the estimate for 2001.

Notes - 2003

Source: Alaska BRFSS

Data for this indicator was not available in 2002. The estimate provided is provisional - it is the estimate for 2001.

This performance measure comes directly from the BRFSS - it is a state specific question that has been available on an alternate-year time frame. Future availability of this indicator is unknown at this time.

Notes - 2004

Data Source: Alaska BRFSS

For 2004, the question on BRFSS addressing this was: "In your lifetime, has an intimate partner ever hit, slapped, punched, shoved, kicked choked , hurt or threatened you?"

a. Last Year's Accomplishments

Training resources were distributed, authored/co-authored by the project director, to promote

screening in the health care setting: toolkit Making the Connection: Domestic Violence and Public Health; and manuals Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health and Identifying and Responding to Domestic Violence: Consensus Recommendations for Women's Health. These training curricula were distributed nationally, at no cost, through the Alaska Family Violence Prevention Project (AFVPP) website with a link to the national Family Violence Prevention Fund (population-based).

The AFVPP resource library and information office/website were maintained and expanded. They responded to 190 requests for educational and training resources. Website activity continues to grow, up from an average of 2000 recorded hits per month in 2000 to over 3000 hits per month during this period (population-based).

Technical assistance was provided on the National Standards Campaign on Domestic Violence, an initiative involving 15 states working collaboratively to improve the healthcare response to domestic violence. The AFVPP also participated in developing and distributing educational film on the impact of domestic violence on children and safety planning, produced by the Alaska Network on Domestic Violence and Sexual Assault (population-based and infrastructure building).

Technical assistance was provided to the Family Violence Prevention Fund to update national consensus guidelines and recommendations for identifying and screening for domestic violence with adult female patients (infrastructure building).

The AFVPP provided technical assistance and resources to 19 domestic violence shelters and advocacy programs in Alaska; distributed educational/training resources; participated in distribution of screening tools; assisted a women's shelter in Valdez, AK with a grant proposal on trafficking women; provided training curricula for staff to use in AK communities; and provided research on health effects of violence on victims and children for training, judicial proceedings, and community education (infrastructure building and population-based).

The AFVPP published articles on Alaska EMS providers as witnesses to the hidden indicators of domestic violence on assessment and intervention for children exposed to violence (July 2003, LifeLines); on developing a coordinated response to domestic violence in the public health setting (Health Alert, Volume 9, winter 2004); and on survivors' perspectives on assessing for lifetime exposure to violence (Health Alert, Summer 2004). The AFVPP also served as active members of the Alaska Women's Health Partnership advisory committee to develop/distribute the women's health guide; served on an advocacy committee for the March of Dimes committee; and placed on an advisory committee for a new statewide mortality review process (infrastructure building).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Serve on steering committee for national conference on domestic violence and health care.				X
2. Author chapter on intimate partner violence for a college textbook.				X
3. Provide technical assistance, education resources and project overview to nursing students and to EMS providers.				X
4. Continue to manage, operate and expand resource library and information office/website.				X

5. Present research on the child witness and pediatric survey at statewide conference on family violence.				X
6. Serve on advisory committees for the Alaska Network on Domestic Violence and Sexual Assault.				X
7. Serve as editor and contributor to Family Violence Prevention and Practice e-journal.				X
8. Conduct onsite domestic violence needs assessments, onsite visits, and follow-up for the Office of Children's Services at six Healthy Families grantee sites.				X
9.				
10.				

b. Current Activities

The AFVPP continues to manage, operate, and expand its resource library and information office/website. They respond to 100-200 requests for technical assistance and training per year. Their website averages over 3000 hits per month. Staff conduct research, update, and expand access to "cutting-edge" research/literature on critical intersection between adolescent brain development, exposure to violence, and substance abuse. New resources for health care and domestic violence (DV) staff are being identified and distributed (infrastructure building).

An extensive, comparative review of national standards has been conducted of the US Preventive Services Task Force's recommendations on preventive practices to identify gaps in the national research agenda on DV and the implications of the latest recommendations on screening for DV. The AFVPP project director served on the steering committee for a national conference on DV and health care in October 2004 and is coordinating a follow-up conference of national DV experts in May 2005 to discuss strategic research priorities for family violence interventions in health care settings (sponsored by the AMA and Family Violence Prevention Fund). The review was also published in the winter 2005 Family Violence Prevention and Practice e-journal (infrastructure building).

The AFVPP project director presented research on the child witness and pediatric survey at an October 2004 statewide conference on family violence, sponsored by the South Peninsula Hospital in Homer, Alaska. She is authoring a chapter on Intimate Partner Violence (IPV) that takes an integrated approach to screening/assessment for DV/IPV and lifetime abuse and other related health problems and risk behaviors (depression, substance abuse, smoking, etc.) for a college textbook to be published by Oxford Press (infrastructure building).

Technical assistance, educational resources, and a project overview were provided to nursing students at the University of Alaska Anchorage in October 2004; to EMS providers at an EMS symposium in October, 2004; and a presentation was given at the Alaska Health Summit in December 2004 (infrastructure building).

The AFVPP serves on advisory committees for the Alaska Network on Domestic Violence and Sexual Assault (including CDC Delta project) and provides technical assistance and resources at statewide conferences and workshops. The project director serves as Editor and contributor to the new, national Family Violence Prevention and Practice e-journal (infrastructure building).

The AFVPP is conducting onsite DV needs assessments, onsite visits, and follow-up for the Office of Children's Services at six Healthy Families grantee sites. Technical assistance, training, and resources are being provided. Site recommendations are being drafted and the AFVPP will participate in a Healthy Families conference for final report recommendations in May 2005 (population-based and infrastructure building).

c. Plan for the Coming Year

Follow-up will be conducted with Healthy Families grantees--including but not limited to technical assistance and training--as requested by the Office of Children's Services. In addition, the AFVPP will plan and conduct a live, national training via videoteleconference on effects of violence on children (requested/sponsored by the Maternal and Child Health Bureau, HRSA). These are infrastructure building services.

Operation, expansion, and improvement of the AFVPP resource library and information office/website will continue, to integrate the latest scientific information and educational resources and incorporate development of online, distance delivery, training curriculum. The AFVPP will continue to respond to requests for technical assistance, training, community outreach (especially for rural communities), and public education; and identify and distribute new resources to health care and domestic violence staff. The AFVPP will continue its collaboration with state, national, and international agencies and organizations. The AFVPP will continue to research, update, and expand the infrastructure and capacity for access to research/literature on biopsychosocial effects of violence on children. These are all infrastructure building services.

The University of Alaska, Distance Education and School of Public Health will collaborate with the AFVPP to develop and deliver an online, distance delivery, training module on violence prevention. In addition, the AFVPP will continue to collaborate on state and national planning, coordination, and policy development to increase capacity and infrastructure for assessment and improvement. The AFVPP will continue to serve on numerous advisory committees, editorial staff, technical assistance and outreach. These are all infrastructure building services.

State Performance Measure 8: *Percentage of People Who Eat Five or More Daily Servings of Vegetables and Fruits*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	27	27	29	29	29
Annual Indicator	24.0	23.0	22.8	22.7	22.7
Numerator	104691	100329	99457	102371	
Denominator	436215	436215	436215	450136	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	29	29	29	29	29

Notes - 2002

Data source: Alaska BRFSS

Notes - 2003

Data source: Alaska BRFSS

Notes - 2004

Data source: Alaska BRFSS

2003 is the most recent data available for the 2006 BG application. The estimate of 22.7% for 2004 is provisional and will need to be updated with the 2007 BG application - it is the estimate for 2003.

a. Last Year's Accomplishments

The percentage of people who eat five or more daily servings of vegetables and fruits is a state performance measure that highlights the importance of nutrition's role in the development or prevention of four of the top ten leading causes of death in Alaska and the United States. The performance measure is placed on the population-based services level of the pyramid because activities related to the Eat Smart Alaska! Projects are focused on outreach and public education (population-based activities). This performance measure is directly linked to the national outcome measures of neonatal mortality and perinatal mortality.

The Section's Community Nutritionist position was moved to Anchorage and filled August 2004. Five a Day materials were distributed statewide to middle school students by the Youth Awareness program September through November 2004. The WIC and Senior Farmer's Market programs were in operation during the summer months. Educational materials and recipes were provided at WIC clinics and senior centers. WIC clinics actively promoted the increased consumption of fruits and vegetables throughout the year. National Nutrition Month promoted the 2005 Dietary Guidelines on the Division of Public Health topic of the month web site and linked to other national and state nutrition resources. The Community Nutritionist also developed a CSFP nutrition education plan that promoted 5 A Day. These are population-based and enabling activities.

The Family and Community Nutritionist reactivated the Eat Smart Alaska Coalition, a statewide public-private partnership to support the promotion of healthy eating and 5 A Day. New and existing steering committee members were reorganized into four active sub-committees that meet on a quarterly basis. The Community Nutritionist also began collaboration with the Alaska Food Coalition, a statewide partnership to promote the availability of healthy food in Alaska (infrastructure building).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Division of Public Health Obesity Prevention and Control Program to promote healthy eating.				X
2. Collaborate with the Alaska Dietetic Association on disease-prevention goals.				X
3. Promote 5 A Day through WIC clinic activities and counseling.		X		
4. Develop and distribute educational materials and recipes.			X	
5. Collaborate in the Healthy Kids Alaska in promoting the 5-A-Day program in the school system and child care centers.				X

6. Continue to work with WIC in promoting the Farmers Market program.				X
7.				
8.				
9.				
10.				

b. Current Activities

Collaboration with the Division of Public Health Obesity Prevention and Control program and the Alaska Dietetic Association continues with related entities in promoting healthy eating, access to healthy foods, and disease-prevention goals. During the year the activities listed above continue.

c. Plan for the Coming Year

The Health and Social Services Office Family Nutrition Services Unit, which includes action steps for 5 a Day, will revitalize its strategic plan by incorporating logic models. The WIC and Senior Farmer's Market activities listed above will continue for 2006. The social marketing campaign for Eat 5 A Day the Alaskan Way will be reinstituted (population-based activity). In partnership with the Child Nutrition Program's Team Nutrition effort, 5 A Day will be promoted in schools statewide (population-based activity). This position will also collaborate with the Alaska Dietetic Association, the University of Alaska Dietetic Internship Program, and the Division of Public Health Obesity Prevention and Control Program to promote the increased consumption of fruits and vegetables (infrastructure building).

State Performance Measure 9: *The prevalence at Birth of Neural Tube Defects per 10,000 live births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	10	10	10	10	10
Annual Indicator	10.4	7.3	5.7	5.7	5.7
Numerator	31	22	17		
Denominator	29863	29945	29923		
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5

Notes - 2002

Source: Alaska Births Defects Registry, Birth Cohort.

Rates of neural tube defects are reported in 3-year averages. 2002 data (2000-2002) is the most recent data available for 2006 block grant submission.

Counts are for children reported with one of thefollowing neural tube defets: anencephaly, spina bifida, and encephalocele. Children reported with more than one ntd were counted only once
.
Data previously reported for 1996-98, '97-'99 and '98-2000 needs to be updated due to a methodology change in reporting this indicator. However, due to the limitations of the TVIS applicaiton system, the changes cannot be made on-line. The updated rates are as follows:

1998 - 9.0 (comprised of 1996-1998 data)
1999 - 9.0 (comprised of 1997-2000 data)
2000 - 8.7 (comprised of 1998-2000 data)
2001 - 6.7 (comprised of 1999-2001 data)

2003 data will be available for 2007 block grant reporting.

Notes - 2003

Source: Alaska Births Defects Registry, Birth Cohort.

Rates of neural tube defects are reported in 3-year averages. 2002 data (2000-2002) is the most recent data available for 2006 block grant submission. The estimate provided for 2003 is provisional and should be updated with the 2007 BG submission - it is the estimate for 2002.

Notes - 2004

Source: Alaska Births Defects Registry, Birth Cohort.

Rates of neural tube defects are reported in 3-year averages. 2002 data (2000-2002) is the most recent data available for 2006 block grant submission. The estimate provided for 2004 is provisional and should be updated with the 2008 BG submission - it is the estimate for 2002.

a. Last Year's Accomplishments

In late FY03, The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), added a modular question on frequency of prenatal/multivitamin use during the last three months of pregnancy as a state-specific question on the new Phase 5 PRAMS survey. These data have never been collected before and will add to the current question of frequency of multivitamin use in the month before getting pregnant. These new data will be available for birth years 2004-2008 (approximately). This is an infrastructure-building service.

In FY04, the folic acid brochure was updated and produced through dollars made available from the March of Dimes-Alaska Chapter. All nurses in the state received a postcard advertising a web-based self-study with free CEU's available through the March of Dimes. Finally additional phone cards were printed with a folic acid message for distribution through public health centers offering family planning services. The phone cards were paid for by MCH Title V block grant funds. These are infrastructure and population-based services.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reproduce and update brochure stressing importance of folic acid supplement, its benefits, and sources of food containing folic acid.				X

2. Distribute folic acid “Purple Lady” posters to tribal community health centers and federally qualified community health centers.				X
3. Public a special edition of the Alaska MCH Data Book featuring information on birth defects.				X
4. Update, print and distribute Healthy Mom/Healthy Baby diary which stresses folic acid supplementation and the reasons why.			X	
5. Distribute postcard to all nurses in state advertising web-based self-study with free CEUs available through March of Dimes.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY05, the Title V/CSHCN director worked with the Health Fairs Alaska Inc. to apply for a March of Dimes grant with the intention of printing an additional 10,000 Folic Acid brochures and distributing the brochures to public health centers, physician offices, non-profits centers that work with teens and pregnant women and job centers. Additional framed "Purple Lady" posters were sent to the tribal community health centers as well as the federally qualified community health centers. State MCH staff has continued to stay active with the March of Dimes in promoting folic acid use prior to pregnancy.

The MCH Epidemiology Unit, Alaska Birth Defects Registry (ABDR) is planning to publish a special edition of the Alaska MCH Data Book featuring information on birth defects in Alaska. This will be the first comprehensive summary of birth defects prevalence published in Alaska. Scheduled to be published in the fall of 2005, the book will provide information on the statewide distribution of major birth defects by birth year groupings, geographic area of residence, race, and other salient characteristics such as maternal age. In preparation for publication of the Birth Defects Edition of the Alaska MCH Data Book, the program will conduct chart reviews for case verification and will estimate the predictive value of a report to the ABDR for prevalent conditions. This comprehensive analysis will provide the first descriptive summary that can effectively be used as a reference for service providers and clinicians, as well as educators and public health organizations on birth defects in Alaska. This is an infrastructure-building service.

Most recently, the results of this study were highlighted in a feature article in the Anchorage Daily News. Janine Schoellhorn, MCH Epidemiologist was interviewed regarding the data analysis looking at the incidence of neural tube defects. Also discussed was the work that has likely contributed to its reduction.

c. Plan for the Coming Year

A reprinting of the Healthy Mother/Healthy Baby Diary is planned using MCH Block Grant money in FY06. This diary contains references to the importance of folic acid supplementation and other foods rich in folic acid. The diaries are distributed to all obstetrical and family practice providers performing deliveries and also public health centers, tribal health clinics and sub-regional facilities as well as nurse midwives and direct entry midwives across the state. This is a population-based service.

State Performance Measure 10: *Percentage of high school youth who feel supported at*

school

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45	45	47	47	49
Annual Indicator			57.6	57.6	57.6
Numerator				19551	
Denominator				33946	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	49	49	49	60	60

Notes - 2002

Source: Alaska YRBS

2001 survey was conducted but due to implementation of "active parental concent" laws sample size for 2001 is too small and therefore unreliable and not reported for the 2004 block grant submission.

1999 survey data does not include Anchorage and is not a statewide representative sample.

/2006/ The estimate provided for 2002 is provisional. The Alaska YRBS cycles in odd years so there is no data for available for 2002. The estimate provided is the actual data available from the 2003 survey.

Notes - 2003

Source: Alaska YRBS

Reliable data is not available for 2004 MCHB Title V Block Grant submission. YRBS was conducted during the spring of 2003 and analysis and reporting of "connectedness to school" will take place by 1/2004.

2001 survey was conducted but due to implementation of "active parental concent" laws sample size for 2001 is too small and therefore unreliable and not reported for the 2004 block grant submission.

1999 survey data does not include Anchorage and is not a statewide representative sample.

Notes - 2004

Data Source: Alaska YRBS

The estimate provided for 2004 is provisional - there is no new data available for this indicator. The Alaska YRBS cycles in odd years and the next updates will available at the end of the Summer/Fall in 2005.

a. Last Year's Accomplishments

Over time, research has linked youth academic achievement, health outcomes and school climate. The National Longitudinal Study on Adolescent Health (JAMA, 1997; 278) identified connectedness as a key protective factor correlated with a decrease in youth risk behaviors. After years of planning and negotiation across departments, seven protective factor questions related to youth feeling connected and supported were added to the YRBS in 2003 and again in 2005. This was intended as a partial measure of positive health status among adolescents. The Section of Epidemiology published the prevalence of connectedness behaviors in the Alaska Youth Risk Behavior Survey 2003 (available at: http://www.epi.hss.state.ak.us/pubs). The MCH Epidemiology Unit will conduct further analysis in 2004-5. This activity was an infrastructure-building service.

As noted elsewhere, the Section of Maternal Child and Family Health was eliminated in FY03 and 04. While several MCH functions were integrated into other state divisions, the Adolescent Health Coordinator position was eliminated. This significantly impacted the coordination of adolescent health programs, services, evaluation, data collection/analysis, infrastructure and system activities. The former Adolescent Health Coordinator was hired by the Division of Behavioral Health as the Resiliency Youth Development Specialist to provide assistance to its grantees as they integrate concepts of resiliency into their services. Former public health/MCFH activities for adolescent health were incorporated as time permitted.

Through a statewide initiative, the former Adolescent Health Coordinator (who now works at the Division of Behavioral Health) worked with the Association of Alaska School Boards to increase the number of Developmental Assets (supports and opportunities that lead to connection, support and positive youth outcomes). The writing of the book, Helping Kids Succeed ~ Alaskan Style and the subsequent materials, resources, training and technical assistance provided are part of that effort. This activity has continued, as an infrastructure-building service.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Epi Unit shared preliminary univariate analysis of the 7 protective factor-based (connectedness) questions with the Resiliency Youth Development Specialist.				X
2. Advocate for inclusion of connectedness variables on the next YRBS survey.				X
3. Launch a youth-friendly business recognition program to promote respect and support for youth by community members.				X
4. Provide input to national survey instrument sponsored by CDC to measure school connectedness and school climate issues in FY06.				X
5. Wrote and disseminated three papers related to adolescent health and connectedness.				X
6. Work with the Association of Alaska School Boards to increase the number of assets through its seven-year statewide initiative.				X
7. Develop instruments to evaluate youth support.				X
8.				
9.				

10.

b. Current Activities

The MCH Epidemiology Unit completed univariate analysis of the seven connectedness questions from the 2003 YRBS. On the advice of researchers in the field, we made the decision not to combine connectedness factors into an index variable (as initially planned), but rather to examine their association with various health outcomes individually. This approach will make it easier to design interventions around connectedness factors that are significantly associated with good health behaviors. Our preliminary analysis indicated that the association between connectedness variables and healthy behaviors was strongly influenced by whether the respondent was male or female and by the outcome of interest. Findings from the preliminary univariate analysis were shared with the Resiliency Youth Development Specialist and used to advocate for inclusion of connectedness variables on the next YRBS survey. Final multivariate analysis will determine the strength of association between connectedness variables and healthy outcomes for Alaskan youth. This activity is an infrastructure-building service.

To increase youth connectedness to communities, a youth-friendly business recognition program was launched in 2004 -5. In the research summarized in Places to Be, Places to Belong, Whitlock (2004) found that youth reported feeling more connected to their community when treated with respect and support by community members, specifically by anonymous adults (defined as police officers and business owners). These activities are infrastructure-building services.

The Resiliency/Youth Development Specialist provided input to a national survey instrument sponsored by the Centers for Disease Control and Prevention that will measure school connectedness and school climate issues in FY06. Three papers were written and disseminated related to Adolescent Health and connectedness: 1) What Gets Measured Gets Done: State Indicators of Healthy Youth Development; 2) What's Health Got to Do with It: Ways Youth- Serving Agencies can Promote Health; 3) Integrating Adolescent Health and Youth Development Among State Agencies (this is in the final review stages). This activity is infrastructure building.

The Resiliency/Youth Development Specialist continues to work with the Association of Alaska School Boards to increase the number of assets (supports and opportunities that lead to connection, support and positive youth outcomes) through its seven-year statewide initiative. The book, Helping Kids Succeed ~ Alaskan Style and subsequent resources, training and technical assistance has been part of that effort. An evaluation of the initiative and the effectiveness of efforts to increase assets is underway with the American Institutes of Research. Another evaluation instrument of youth support (Grading Grown-ups ~ Alaskan Style) was developed, conducted statewide and in several local school districts. This activity is an infrastructure-building service.

c. Plan for the Coming Year

The Resiliency Youth Development Specialist from the Division of Behavioral Health will continue to work across state divisions to promote and integrate adolescent health with youth development. She will continue providing leadership and guidance to the statewide Assets initiative with the Association of Alaska School Boards.

The MCH Epidemiology Unit will finalize multivariate analysis of the association between connectedness variables and important youth behavioral outcomes, using the 2003 YRBS data. The final analysis, along with practical interpretations of the data and suggested recommendations, will be presented to an assemblage of adolescent health and youth development specialists. Based on input from this group, the Section of Women's Children's and Family Health will determine which, if any, YRBS questions on connectedness are

predictive indicator(s) of positive health outcomes and whether they would therefore serve as reliable indicators for planning and evaluating interventions designed to improve poor youth behavior outcomes. These are infrastructure activities.

E. OTHER PROGRAM ACTIVITIES

The Section of Women's, Children's, and Family Health participated in the 9th annual Baby Fair at Children's Hospital at Providence. A tabletop display and brochures offered information on topics such as early hearing detection/intervention, newborn metabolic screening, oral health, and basic life support. Approximately 10,000 people attend the fair.

Oral Health: The State of Alaska Oral Health Program (OHP) participated in the village of Nuiqsit's annual health fair sponsored by Alaska Health Fair, Inc. Children learned about oral health via a "Smile Alaska" display produced by OHP. The interactive display features Alaska animals. Oral health information and toothbrushes were given to parents and children.

OHP worked with the Commissioner's Office and Alaska Mental Health Trust Authority to develop a Governor's bill to expand adult Medicaid to include preventive/restorative dental services (currently limited to emergency services). OHP also worked with oral health work group members on a legislative resolution supporting community water fluoridation. The dental officer (DO) assumed responsibility for Medicaid policy development around dental/dental provider issues including coverage of new dental procedures, dental reimbursement policy development, dental provider enrollment and provider relation activities. The DO responded to requests in relation to tribal dental program development of a Dental Health Aide/Dental Therapist program as a means to increase access to dental service needs in rural Alaska.

The DO chairs the Association of State and Territorial Dental Directors (ASTDD), Head Start Oral Health Work Group, in convening state/regional forums on oral health issues/needs for Head Start Programs. The DO also serves on the Executive Committee of ASTDD.

Specialty Clinics: Specialty Clinics Coordinator presented information about cleft lip and palate to students enrolled in the University of Alaska Anchorage (UAA) Dental Hygiene Program. Students were quite interested in the topic and a few students expressed interest in observing at state-sponsored Cleft Lip and Palate Clinics. UAA Dental Programs was invited to enter a Memorandum of Agreement with the state to allow student involvement the clinics.

MCH Epidemiology: Three H.Pylori articles are completed, submitted and awaiting journal decisions. The pediatric epidemiologist completed an article on asthma in Alaska and is currently waiting on the CDC's review prior to publication. In addition the following articles were published:

Gessner BD, Bruce MG, Parkinson AJ, Gold BD, Muth PT, Dunaway E, Baggett HC. A Randomized Trial of Triple Therapy for Pediatric Helicobacter pylori Infection and Risk Factors for Treatment Failure in a Population with a High Prevalence of Infection. Clin Inf Dis. In press.

Bruce M, Parkinson A, Gessner B. Does delayed testing of urea breath test samples effect results? Digestion. In press.

Gessner BD, Castrodale L, Soriano-Gabarro M. Etiologies and risk factors for neonatal sepsis and pneumonia mortality among Alaskan infants. Epidemiol Infect. In press.

Castrodale LJ, Beller M, Gessner BD. Over-Representation of Samoan/Pacific Islanders Among Patients with Methicillin-Resistant

Staphylococcus aureus (MRSA) Infections at a Large Family Practice Clinic in Anchorage, Alaska, 1996-2000. Alaska Med 2005;46:88-91.

Gessner BD, Neeno T. Trends in asthma prevalence, hospitalization risk, and inhaled corticosteroid use among Alaska Native and nonnative Medicaid recipients less than 20 years of age. Ann All Asth Immunol 2005;94:372-9.

McLaughlin JB, Gessner BD, Bailey AM. Gastroenteritis outbreak among mountaineers climbing the West Buttress route of Denali -- Denali National Park, Alaska, June 2002. Wilderness Environ Med 2005;16:92-6.

McLaughlin J, Gessner B, Lynn T, Funk E, Middaugh J. The association of regulatory issues with an echovirus 18 meningitis outbreak at a children's summer camp in Alaska. Ped Infect Dis J 2004;23:875-7.

Epidemiology Bulletin. Pregnancy-associated mortality in Alaska, 1990-1999. Section of Epidemiology, Alaska Division of Public Health. No. 16, 2005.

Epidemiology Bulletin. Decline in the prevalence of neural tube birth defects, Alaska, 1986-2004. Section of Epidemiology, Alaska Division of Public Health. No. 15, 2005.

Epidemiology Bulletin. Salmeterol and montelukast use in the treatment of pediatric asthma. Section of Epidemiology, Alaska Division of Public Health. No. 10, 2005.

Epidemiology Bulletin. Trends in asthma prevalence, hospitalization risk, and inhaled corticosteroid use among Alaska Native and non-Native Medicaid recipients less than 20 years of age. Section of Epidemiology, Alaska Division of Public Health. No. 23, 2004.

Pregnancy Risk Assessment (PRAMS): There were two major accomplishments/activities for PRAMS during this period. The first was publication and distribution statewide and to national colleagues of the Alaska Maternal and Child Health (MCH) Data Book 2003. It was a major undertaking by the MCH Epidemiology Unit and is the only comprehensive resource for MCH Data for Alaska. Several presentations promoted it and it was well received. The second was preparation for and smooth transition to the Phase 5 version of the Alaska PRAMS survey. This is the fourth version of a PRAMS survey used in Alaska; in addition to core questions, state-specific questions that will be asked of 2004-2007 births include oral health, postpartum depression, and smokeless tobacco use that distinguishes between commercial chew and iq'mik. This is the first time Alaska has had these type of questions.

FAS Surveillance: Alaska Public Health Conference as part of an MCH unit presentation:
Data to Action. Staff participated in the Anchorage School Board meeting on FASD, and training was provided at the Family Services Training Academy launching of new curriculum FASD 201. They also exhibited with the Alaska Office of FAS at the 3rd Annual Building State FASD Systems Meeting held in the fall of 2004.

F. TECHNICAL ASSISTANCE

/2006/ A request for technical assistance has bee submitted requesting funds to have one or two MCH staff attend the National Network of State Adolescent Health Coordinators. This meeting will provide an opportunity to lean what other federal agencies and states are doing in the area of adolescent health and to network with other states that may have limited or no

funds for adolescent health coordinators, and to provide input into future directions, i.e. the natioal inititiative to improve adolescent health. The estimated cost for one person to travel would be $1600 from Alaska. We feel this important to stay in touch with other states and their adolescent program and stay abreast of potential funding opportunities as no funding exists at the present time for the state of Alaska to have an adolescent health care coordinator //2006//.

V. BUDGET NARRATIVE

A. EXPENDITURES

/2006/ As is noted on forms 3, 4, and 5 of the application, the amount of funds expended in FY04 were less than budget due to the effects of the reorganization and the absorption of many expenses especially in the personnel category by the Division of Health Care Services (a.k.a Medicaid). A significant portion of General funds were supplanted with federal and state match dollars specifically.

As a result of the reorganization of DHSS, programs that had been part of the Section of Maternal, Child and Family Health were distributed to 5 divisions and a significant portion of general fund dollars and Medicaid school base funding went away. As a result, many positions were lost and programs were either cut, absorbed into other programs or were stopped. Specifically funding for Adolescent health, pregnancy prevention, MIMR, family nutrition, and injury prevention was lost. In addition with the distribution of programs to divisions other than where the Title V/CSHCN director is, the oversight of other federal grant programs and state G.F. was eliminated which affected the changes in reported expenditures.

With the reorganization that has gone into effect for FY06, many of the MCH program are being reformulated into the Section of Women's, Children's and Family Health and staff in those programs have been transferred back into the Division of Public Health. With that change comes a financial management team that is much more accustomed to working with federal grants and detailed reporting using ledger codes and other accounting structures related to grant management//2006//.

B. BUDGET

/2006/ Form 2 outlines our proposed budget for the coming federal fiscal year. For Fy06, children's preventative and primary care comprise a minimum of 30% of the anticipated federal allocation. CSHCN reflects 33% of the federal allocation and includes expenditures for spending in the areas of direct services for pediatric specialty clinics to increase access to services and parent navigation (family care coordination). Administrative expenditures are budget to be no more than the allotted 10% of the budget.

Of note is that support from federal dollars has become the primary base of support and acts as either secondary or primary dollars for infrastructure or population-building services. The amount of general fund support has markedly decreased overtime and has been supplanted by Medicaid dollars in some cases or support has been eliminated altogether as outlined in the report on expenditures.

Budget priorities for FFY06 are focused on the new state performance measures identified as part of the 5 year Title V needs assessment and the national performance measures. This will include adding a new position to focus on perinatal and neonatal issues in support of primary and preventive care in the perinatal period. The current Title V/CSHCN director was originally hired to develop this program, but due to changes in structure and priorities over the last couple of years, roles have changed and it is not possible to add this to the work load of the director position. In addition, with the loss of federal and state general funds for the mandated morbidity and mortality review committee and the Alaska birth defects registry, the MCH Title V block grant will be covering the costs of these very important programs. Finally, dollars from the Title V block grant will be distributed to other divisions and sections that support some of the MCH priorities //2006//

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.